Karen Skerrett · Karen Fergus *Editors*

Couple Resilience

Emerging Perspectives

Springer

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To my family, for their love
and inspiration – KS

To Ken, for your love and support,
day in and day out – KF

And to the resilience of couples everywhere

Preface

The capacity to deal effectively, even creatively, with the challenges life brings our way is a topic of endless interest to scholars, clinicians, and researchers from a wide variety of disciplines. Over time, the focus has expanded from how one adapts in the face of adversity to how one might thrive. This book broadens the focus even further by applying the concept of resilience to relationship dyads and, specifically, to the ways in which resiliency expresses itself within an intimate relationship. Also of interest are the processes underlying this ability for relationships to endure adaptively and for partners to grow together in the face of life's ups and downs. A primary motivation for embarking on this project was a keen interest in the ways in which committed relationships impact coping and the ways in which coping efforts shape a relationship. It reflects the shared passion of two academics with originally independent interests in couple adaptation and the relational forces that promote coping. Over 10 years ago and in two different countries (USA and Canada) we had been individually studying couples who were coping with a breast cancer diagnosis. We discovered that we were both intrigued by a similar finding that couples with better outcomes on a variety of dimensions approached the cancer challenge from a unified, 'team' perspective. Our interests have since developed into an ongoing collaboration, one that is nourished by the desire to explore new ground in the couple relationship literature. The goal of this volume is two-fold: (1) to identify dynamics and properties unique to relational resilience and (2) to showcase the cutting edge thinking of scholars who are investigating these dynamics in various contexts. This book is intended for relationship scholars, those interested in deepening their understanding of resilience in intimate contexts and is suitable for courses in counseling, health, psychology, and social work.

Decades of work have examined resilience – the ability to transform challenge and adversity into adaptive outcomes – as an individual trait or characteristic. Despite the vast literature on individual resilient processes and outcomes, little has been done to examine qualities specifically involved in couple resilience. We have long known the profound impact close relationships have for the health and well-

being of partners in committed relationships. However, the couple literature, like psychology in general, has been skewed toward an emphasis on the more problematic, as opposed to life affirming, aspects of relational dynamics. This oversight has, in turn, contributed to a tendency to underestimate the human capacity to thrive and grow through challenge, as well as the capacity to grow as a relational entity in response to a shared challenge. This volume is our initial attempt to address such a gap by expanding current understanding of dynamic, growth promoting processes, as well as to identify resilient qualities that may be exclusive to the couple relationship. Ideally, this will lead to further investigations of the specific relational variables that can be identified and linked to resilient outcomes among couples.

Over the course of the past decade, one relationship process has emerged with greater frequency and clarity as critical to couple resilience. This process has to do with the couple's ability to approach life's challenges with a collective orientation that draws upon the couple's unique resources (both shared and individual). Variously referred to as 'communal,' 'dyadic' or 'collaborative' coping, and 'we-ness', this is the first volume to focus on this dynamic specifically, and to explore its promise and potential for relationship functioning. Accordingly, the construct of we-ness serves as an organizing principle for the volume with each contributor speaking either to an *integral facet* of the 'we' such as sexual intimacy, mutuality, shared memory, the capacity to forgive, or to the *holistic integrity* of the 'we' as in the 'essence' of a marriage, the intersubjective processes that bind partners together, or an examination of interpersonal coping within its broader sociocultural context.

It is important to situate the notion of committed partnerships within a broad historical, cultural and economic context. During the last half of the twentieth century, for the first time in human history, divorce replaced death as the most common endpoint of marriage. Since then, new options have evolved for the establishment of mutually exclusive and enduring dyadic relationships, or pair-bonding. These alternatives include but are not limited to cohabitation and non-married co-parenting. The factors behind the death-divorce shift are associated with and driven by three changes: the increased lifespan in western civilization, the shift in biopsychosocial roles of women, and legal and social value changes (Pinsoff, 2002). Because these shifts are likely to endure as long as the motivating conditions continue, Pinsoff (2002) calls for marital theory development to be replaced by the more inclusive notion of 'pair-bonding theory' as a way to acknowledge and address the viability of these multiple arrangements. In the spirit of such clarity, this volume locates marriage as a permanent pair bond and a relationship that is predicated on a love based, mutual value commitment to a lifelong often monogamous partnership. We acknowledge here that some long term, intimate partnerships also entail sexual agreements where it is normative and acceptable for partners to engage in sexual relations with others outside of the relationship. Such relationships would still fall within the scope of this work because there remains an intentional commitment to a particular other as the primary attachment and love figure. It reflects a Western civilization perspective, essentially North American and Euro-American and Euro-Canadian.

Specifically within the last 40 years, marriage and family life has been destabilized by two powerful forces: progress toward equality between men and women, and the growth of socioeconomic inequality and insecurity. These trends have changed the risks, rules and rewards of marriage (Coontz, 2014). The many alternatives to marriage referred to earlier, coupled with greater expectations for mutuality and equality, have resulted in the institution of marriage being more intimate, fairer and less violent but also have made it less likely that individuals will stay in unsatisfactory marriages (Coontz, 2006). In general, African Americans have experienced the same trends as White and Hispanic North Americans but only more so. Individuals are increasingly pairing off along class and education lines (Coontz, 2014). For example, the college educated are currently more likely to get married and stay married. Finkel (2014) argues that today's average marriage is weaker than the average marriage of yore in terms of satisfaction and divorce rates, but that the best marriages are much stronger. In describing the evolution from the companionate to the self-expressive marriage, he claims Americans have gradually elevated their expectations of marriage. The expectation that marriage will contribute to one's personal growth has resulted in unprecedented high levels of marital quality. The caveat is that such high quality is only possible for those able to invest a great deal of time and energy into the endeavor. Given that 'being married' is no longer sufficient motivation for staying married, and that there are socio-cultural and legal structures in place now that make it more acceptable and easier for partners to separate, efforts to unpack the components of the venerate 'optimal marriage' are needed. It is a good time to reexamine those components empirically and conceptually, something we have endeavored to do here under the umbrella of 'couple resilience.'

We have organized the volume in the following way. The initial chapters offer an overview of the domain of resilience in couples, defining the territory and summarizing significant literature. The topic is introduced from two sides of the coin: exploring the resilience afforded couples through this mutual self-sense or 'we-ness,' and then examining what it is about this 'we-ness' that promotes resilience. We then go on to elaborate on particular processes that contribute to, or underlie, couple resilience such as neurobiological and sexual processes, and how the concept of resilience applies to specific populations such as gay and lesbian couples, or couples where one partner is HIV positive or affected by cancer. The final section of the book focuses on empirical investigations or programs of research that examine resilience through a particular lens such as the importance of partner identification with the relationship, partners' mutual prioritization of the relationship, and the relevance of 'we-talk' in relationship-defining memories and its association with marital satisfaction. The final chapter in this section on the process of forgiveness was intentionally selected also to be the concluding chapter in the sequence of contributions – for where would 'we' be without the ability to forgive ourselves as well as our partners in our bumbling attempts to adapt to life and the unsavory array of challenges it throws our way, each time anew.

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Leslie S. Greenberg, Ph.D., is a distinguished research professor emeritus of psychology at York University in Toronto. He is the author of *Emotion-Focused Therapy: Theory and Practice* (2010) and has coauthored *Emotion in Psychotherapy* (1986), *Emotionally Focused Therapy for Couples* (1988), and more recently *Emotion-Focused Couples Therapy: The Dynamics of Emotion, Love, and Power* (2008) and *Working with Narrative in Emotion-Focused Therapy* (2011). He has received the Distinguished Research Career Award of the International Society for Psychotherapy Research and the Distinguished Professional Contribution to Applied Research Award of the American Psychological Association as well as the Canadian Psychological Association Professional Award for distinguished contributions to psychology as a profession. Dr. Greenberg is a past president of the Society for Psychotherapy Research (SPR) and an originating member of the Society of the Exploration of Psychotherapy Integration (SEPI). He conducts a private practice for individuals and couples and trains people in emotion-focused approaches.

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About the Editors

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Part I
Couple Resilience and We-ness

Chapter 1
Resilience in Couples: A View of the Landscape

Karen Skerrett

Resilience in Couples: A View of the Landscape

There continues to be considerable interest in the properties and processes that promote optimal functioning in the lives of individuals and committed partnerships (Fehr, Sprecher, & Underwood 2009; Maisel & Gable, 2009). Optimal functioning, including factors such as strengths, virtues, resilience, compassion and positive emotions, qualifies what makes life most worth living and is placed in complementary position to the traditional problem-focused or deficit-based paradigms.

If we attempt to identify exactly what optimal functioning looks like for individuals, let alone couples, it becomes obvious that this complex concept is both dynamic as well as responsive to the multiple challenges life presents across the span of togetherness. What may be optimal for a newly partnered pair is quite different than what will be optimal 5, 15 or 40 years forward. As individuals live longer, it is important to utilize concepts that are at once representative of particular relationship dynamics as well as flexible enough to accommodate change over time. The dynamics must incorporate those challenges that arise from the normative evolution of individual developmental change, "natural resilience" (Bonanno, 2005), as well as challenges of an unanticipated or traumatic nature. In this chapter, I propose an expanded view of resilience and explore it as a couple phenomenon as compared to individual resilience, with unique qualities and processes. I conclude by offering directions for future research and suggestions for therapeutic, educational and enrichment work with couples derived from the dynamics proposed.

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Coping, Resilience and Optimal Functioning

The related concepts of resilience and coping remain at the foreground of attempts to understand the qualities that assist couples to respond to challenges over time. While concepts of optimal functioning, flourishing, resilience and coping exemplify life enrichment models of behavior, it is important not to confound what might be subtle, yet important conceptual and practical differences between them. Flourishing is typically defined as a state of optimal mental health, one in which individuals not only feel good but do good (Catalino & Fredrickson, 2011). Flourishing may or may not involve the presence of adversity or stressors. At this level of functioning, one is said to be "thriving." Resilience, on the other hand, depends upon two conditions. There must be the presence of a significant threat or risk to one's wellbeing and second, there must be evidence of a positive adaptation despite the adversity encountered (Janssen, VanRegenmortel, & Abma, 2011). If a stressor is perceived as threatening, different types of coping processes are activated and the mobilization of strengths further influences the extent to which the threat unfavorably affects one's functioning and development. Ungar and Lerner (2008) state that the study of resilience and positive development across life are essentially the same enterprise. They make the important distinction that while the examination of positive development does not presuppose development under stress, the notion of resilience is usually reserved for those situations where successful growth is beyond that which is expected given the challenges of daily life. They also argue for an expanded focus that includes both the examination of coping with adversity and loss, as well as the examination of positive emotion, psychological strengths, and the regenerative capacity necessary to achieve growth and healthy longevity.

Resilience, most often defined as the capacity to bounce back after challenges (McCubbin & McCubbin, 1988), developed from the domain of developmental psychology and the positive adaptation of children under adverse circumstances (Rutter, 1987). As a concept, resilience continues to hold wide appeal across a variety of disciplines and Richardson (2002) suggests that it is best seen as a metatheory, one that incorporates many areas of inquiry to explore individual strengths and developmental outcomes. Examinations of resilience have been extended to later periods of the lifespan including old age (Blieszner, 2007; Cheung, 2008; Janssen et al., 2011; Masten & Wright 2012; Yorgason, Piercy, & Piercy, 2007) as well as to the study of family systems (Black & Lobo, 2008; Walsh, 2011).

This chapter builds upon the work of Walsh (2011), Jordan & Carlson (2013), Surrey, Shem, and Bergman (1998) and others (Fergus, 2011; Kayser, Watson, & Andrade, 2007; Lepore & Revenson, 2006; Luthar 2006; Reid, Dalton, Laderoute, Doell, & Nguyen, 2006; Singer & Skerrett, 2014; Skerrett, 2010, 2013) by attempting to conceptualize a unique aspect of adult relational resilience, one reflected in a property called couple we-ness. Evidence is accruing that we-ness and the capacity to cope dyadically may have a protective influence on couple adjustment (Fergus, 2011; Singer & Skerrett, 2014). Despite the vast literature on individual adult resilient processes and outcomes, little has been done to highlight qualities specifically

involved in couple resilience. We are not claiming we-ness to be the only or preferred way that couples respond to the challenges of relational life but rather offer it as a phenomenon that may be particularly unique to couple coping processes. Clearly, just as there are multiple pathways to resilient outcomes for individuals, the same is true for couples. Key components of this dynamic emerged from ongoing, qualitative research in several groups of couples (Singer & Skerrett, 2014; Skerrett, 2013).

Resilience in Adulthood: The Big Picture

Students of adult development are increasingly being encouraged to pursue positive functioning, the rationale being that deficit-based approaches do not adequately address the full range of human potential. In fact, Kelley claims (2005) that psychologists have dramatically underestimated the human capacity to thrive after adversity and promotes the notion that all humans possess a natural capacity for resilience. Due to the recent advances in neuroscience, we now know that biochemical, genetic, and behavioral factors act together to restore our emotional equilibrium and that many individuals demonstrate astonishing natural resilience to the worst of life's experiences (Bonnanno, 2009). Bonanno has conducted numerous studies documenting the varieties of resilient experience, focusing particularly on individual reactions to the death of a loved one as well as responses to war, terror, and illness. The bulk of his work points to the fact that the majority of individuals, after an initial period of distress, return to functioning within a matter of months. Seligman and Fowler (2011) suggest that resilience is normally distributed- on one tail of the distribution are a minority who collapse in the face of adversity, in the middle are the great majority and on the other tail are those who achieve a higher level of functioning than they began with, so called post-traumatic growth. Lepore and Revenson (2006) proposed a tripartite process of responding to stressors: recovery, resistance and reconfiguration and Levine and colleagues (2009) examined comparisons between resilience and posttraumatic growth.

Major findings from over four decades of research in resilience are relatively consistent and are generally summarized in terms of protective and promotive factors associated with positive outcomes in diverse situations and populations. These factors, such as good parenting, self-regulation skills, or community resources, underscore that resilience arises from ordinary processes that serve to protect development under diverse conditions (Masten, Cutuli, Herbers, & Reed, 2009). Protective factors associated with coping from a couple perspective may include but not be limited to communication skills, beliefs regarding commitment, the relationship quality prior to the challenge and individual levels of mental health and religiosity/spirituality. Marriage itself, is widely thought to be a key protective factor for adult functioning (Kiecolt-Glaser & Newton, 2001). What exactly it is that is protective about marriage was part of the impetus for initiating our current research projects (Singer & Skerrett, 2014).

The two major approaches used to study resilience are described as variable-focused and person-focused (Masten & Wright, 2012). In variable focused, attempts are made to identify patterns among measures of characteristics of individuals, environments, and experiences in order to isolate what accounts for a good outcome when risk is high. Person-focused approaches typically look to case studies or the examination of a highly resilient sub-group of individuals in order to understand their assets and protective factors. However, developmental theories about resilience are considerably more dynamic than the research to date and assume that many levels across multiple systems are involved in the processes that lead to resilience (Cicchetti & Curtis, 2007; Curtis & Cicchetti, 2003; Masten & Obradovic, 2007). Pathways through life do not depend solely on individual or relationship strengths. Social location, gender, race and ethnicity, social class, and sexual orientation are all important determinants of life's opportunities and constraints.

Despite the fact that the resilience literature evolved through the study of children and adolescents recovering from traumatic conditions, results are often applied to adult functioning. Bonanno (2005) identifies two key differences between resilience in children and resilience among adults. First, he claims that resilience among adults represents a unique and empirically separate outcome trajectory than that associated with recovery from trauma in children and that there are multiple factors that inform adult resilience. Second, adults who experience potentially challenging experiences typically do so in the context of otherwise normal circumstances. The potentially traumatic event may be of brief duration and most adults have access to a greater array of resilience promoting factors. This highlights the particular relevance of behavioral flexibility, including emotional regulation, for adult resilience. Consider the couple encountering a partners' job loss. While often very disruptive and potentially traumatic, it is likely that partners bring a coping repertoire that includes previous experiences with job change or loss, financial resources in family and friends, the wage earning potential of the other partner and, critically, the support and understanding potentially available within the relationship itself.

For adults, resilience may be more of an inferential concept. It still involves some expectations for behavior and some exposure to challenge. Always implicit is the capacity for transformation and change—a property we now know extends well into old age. Bonanno (2005) summarizes adult resilience as characterized by a stable trajectory of healthy functioning across time, as well as this capacity for generative expression and positive emotion. Richardson (2002) suggests that what may be key to long term healthy functioning is the repeated reintegration of resilient outcomes that result from dealing with challenges. While resilience can be cultivated all along the family life cycle and learning positive coping strategies can enhance individual and family functioning during normative and unanticipated challenges (Patterson, 2002), less work has been done to examine these processes exclusively in committed relationships.

Neff and Brody (2011) agree that more needs to be known about the amount of stress marriages can withstand and the factors that aid in developing greater resilience. Seeking to address this gap, they examined resilience in two groups of couples-those in early marriage and those following the transition to parenthood.

They identified that one potential mechanism underlying the development of couple resilience was the experience of success in managing difficulties. If couples have adequate resources for addressing moderate stress in their lives, exposure may cultivate the belief of effectiveness. They concluded that spouses need both good initial resources plus the chance to practice in order to develop resilience.

Couple Resilience: From "I" to "We"

A pioneer in calling for systemic approaches to resilience, Walsh (2011) has long advocated nesting the concept into a multileveled, contextual perspective. Challenging the individualistic cultural bias, Walsh's definition of resilience is relationally based; one in which life crises are approached as shared challenges and a positive outlook is critical as is the ability to utilize spiritual, transcendent resources. While we know that every marriage brings not only promise but substantial risk, to date we know more about the harmful processes in relationships than we do about what makes them work (Maisel & Gable, 2009).

Walsh (2011) identifies empathic reciprocity as the key to relational resilience. Also described as relational empowerment (Fishbane, 2010, 2013) compassionate love (Neff & Karney, 2009) and relational competence (Hansson & Carpenter, 1994), relational resilience encompasses a collective emotional and social intelligence that includes awareness and factors such as generosity, curiosity, healthy boundary setting, and interpersonal sensitivity. These elements can be thought of as contributing to the "bounce back" quality of resilience and are essential to relational repair work during couple distress (Fishbane, 2010; Skerrett, 2004).

From a neuroscience perspective, we are talking about neuroplasticity. Resilience depends on the brain's capacity to change the patterns of energy and information or neural connectivity in response to new experiences (Siegel, 2006). Clinical scholarship has demonstrated that the reason it is so difficult for clients to modify self-defeating narratives is because these narratives are woven into the fabric of internal states which are hard-wired in the sense that they are neurologically based and automatically activated in daily living, often without conscious awareness (Atkinson et al., 2005). The foundation for change lies in the brain's ability to modify such wired-in painful experiences by activity both within an individual mind and between minds. When partners work through a stressful set of circumstances in their lives and arrive at a state of well-being, they have moved toward a condition of greater neural integration. Neuroscience literature clearly frames resilience for intimate partners within a system of mutual regulation (Atkinson, 2005; Cosolino, 2006; Fishbane, 2007, 2013). Many biological pathways contribute to this multifaceted process. Each partner in a relationship brings unique sets of responses that have been epigenetically translated into actual brain structures (Cosolino, 2006). These systems work alongside the attachment system, are embedded in procedural memory and prepare partners to move toward or away from each other, based on history and experience. Biologically, in a primary attached relationship, it is more efficient for

one partner to manage the other's arousal state than their own (Solomon & Tatkin, 2011). This reflects the reality of our wiring such that at close distance, one can see into the other's internal state before recognizing one's own. Such a regulatory system highlights the interactive, mutual nature of couple resilience (Solomon & Tatkin).

Another critic of the traditional separate self model of development, Jordan (1992) outlines five components of relational resilience. They are supported vulnerability, mutual empathic involvement, relational confidence and empowerment, and creating meaning in expansive relational awareness. Jordan posits disconnection as the primary source of stress in individual lives and sees change as resulting from awareness and the development of a more differentiated and flexible means for reconnection. This Relational-Cultural theory of the Stone Center (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) has previously been applied to couples (Skerrett, 2004, 2013).

A recent term intended to capture relational dynamics is social resilience (Cacioppo, Reis, & Zautra, 2011). This notion emphasizes an individual's capacity to work with others, is intrinsically multileveled and can result in outcomes that transcend those that would be obtained from individual resilience alone. According to these authors, what is unique about social resilience is the potential for coordinated benefits, the sense of connection and 'we-ness'.

Building on the earlier work of Surrey, Shem, and Bergman (1998), 'we-ness' has been defined as the sense of mutual identification a couple describe as the lived experience of their relationship. Couples frequently and spontaneously use the words "we" and "us" in talking about this quality (Skerrett, 2010). It is a kind of thinking that reflects receptivity and the integration of the other's perspective in one's own and has been found to have defining as well as adaptive qualities throughout a couple's relationship (Skerrett, 2003, 2004, 2013). Reid (personal communication, 2010) in describing his development of a we-ness scale, stated that the measure incorporates a high level of self-other awareness and self-reflexivity and that partners can see how these two components interconnect. Just such a level of self/other and relationship awareness is what creates the "we." Reminiscent of Bowenian thinking (1978) and Bader and Pearson's (2000) model of couple differentiation, we-ness actually supports both the independence of partners and their capacity for intimacy.

Differentiation, the dynamic process of self-expression, also means being able to tolerate, support, and enhance one's partner in doing the same. This lays the framework for connection and individual as well as relational growth. In fact, Reid et al. (2006) reports that changes in partners sense of self in relation led to robust improvement in marital satisfaction in two studies and a follow-up.

Thus, a growing body of scholarship is accruing that points to the profound impact close relationships have on health and well-being. Specifically, marriage appears to be related to positive health and positive psychological outcomes when the marriage is happy and non-distressed (Hawkins, 2005; Kiecolt-Glaser & Newton, 2001). Yet, given the reality that life presents many challenges that impact the emotional tenor of a relationship, how is it possible to deal with the stressor *and*

think and act with the best interests of the relationship in mind? How might the individual stories of wants and needs translate into a joint story that might enhance coping efforts? With these questions in mind, a series of studies was designed to explore ways that couples describe coping with various challenges in their relational lives and highlighted the critical importance of qualitative aspects of the relationship (Singer & Skerrett, 2014; Skerrett, 2010, 2013).

Story Projects

Story-telling in nonclinical (Skerrett, 2010) and clinical (Skerrett, 2013; Singer & Skerrett, 2014) couples was examined and has been reported elsewhere. The protocol for the nonclinical sample can be summarized briefly. Thirty couples were identified through convenience sampling and paid a nominal fee for their time. Twenty one were Euro-American, seven were African American and two were Asian. All were in first marriages from 30 to 43 years in length. By virtue of their marital longevity, they offered more experience with meaning making and relational wisdom. These were couples who had time to develop their shared stories and as volunteers, self-identified as being willing to talk about their relationship. Couples were interviewed at length using the Life Story Protocol of McAdams (2001). Interviews were tape-recorded and lasted from 1 to 2 h. Partners were then asked to write a two page summary based on the interview questions, calling it their 'Life Story.' Qualities of 'good enough' stories were identified and couples were then coached by the investigator to blend their individual life stories into a 'Couple Story'. Interview transcriptions were read by the investigator and three outside raters familiar with the Life Story Protocal and theme identification (see McAdams, Diamond, & de St. Aubin, 1997). The verbatim transcriptions were read multiple times, coded and the coded interviews became the data source for evaluation. Reliability across all raters on all transcriptions achieved 91 %. The theoretical framework followed the phenomenological tradition, particularly Giorgi's method of data analysis and coding (1985). Each partner's narratives were organized into the broad categories addressed by the interviews.

The majority of our couples (22) were able to develop 'couple-stories' and even name their stories, such as "Caring and Sharing", "The Dream Team", "The Resilient Duo," and "Everyday a Little Better". The nine couples who had difficulty creating a joint story from the directions given told stories with considerably less evidence of reflection. They gave a more superficial reporting of life events, with less complexity, coherence or thoughtful interpretation of their experiences. For example, one husband commented, "I gotta tell you, I really tried to think about these questions but I can't come up with much. I'm a guy that just tries to do what needs doing-I guess I'm not a thinker about these kinds of things".

The couple stories, those shared by both partners about their relationship appeared to lend a sense of meaningful coherence and guide for engagement. The stories reflected a mutual identity that couples spontaneously described as the experience of 'we-ness'.

Couples who were successful in creating a couple story commented that the task assisted them to expand their awareness of the relationship- their 'we' consciousness.' The process of co-creating their stories appeared to enhance relational processing or the ability to think about self in relation to other, take perspective or empathize and apply that knowledge to relate to one another (Reid et al., 2006). These partners also remarked that the mutual vision (the 'we-ness' of their partnership) was the quality that helped them not only adjust to life's challenges, but also helped them develop as individuals.

Since the initial project, we have continued to collect couple stories in couples presenting for treatment (Singer & Skerrett, 2014; Skerrett, 2013) as well as non clinical couples to a current n of 46, expanding the number of years married from 15 to 55 years. They now include African American, Indian, Asian and partnered but unmarried LGBTQ pairs.

Our data analysis increasingly supports that the notion of relational resilience can be exemplified in 'we-ness.' Stories show evidence of partner willingness to work together, interpersonal sensitivity, generosity and the ability to set boundaries with a confidence that both separate and coordinated action would lead to mutual benefit. In addition, stories qualifying as 'we-stories' showed evidence of security, empathy, respect, acceptance, pleasure, humor, and shared meaning and vision (SERAPHS) (Singer & Skerrett, 2014). The following story dimensions emerged as key: self/other and relationship awareness; empathy and respect; mutual vulnerability; the joint creation of meaning; skill sets to support relational positivity, and the reintegration of relational wisdom. We will look at each proposed component in turn. As with any systemic model, components do not operate linearly but in an integrated, dynamic fashion where each component builds off and enhances others.

Self/Other and Relationship Awareness: Empathy and Respect

Essential to relational resilience is the ability to notice what it is we are picking up in the internal state of the other, then to internally self-reflect and identify one's own thoughts, feelings, wants, and desires. Once known, individuals can develop the ability to congruently express and expose more of who they are to one another. Partners can learn how to notice the relationship and understand how each person contributes to relationship functioning. To put in other terms, it is the capacity to shift from the individual brain to the couple brain in a back and forth manner (Badenoch, 2008). Through the process, couples can distinguish self from other, take ownership of the personal and appreciate how an individual response has consequences for a partner and how the partner's response reciprocally impacts their response. In this way, they identify with the relationship and understand that it is an entity incorporating but separate from either of them as individuals. They are also learning to develop a coherent individual and couple narrative, which becomes grounded in a securely functioning relationship. Consciousness of the relationship is clearly the most challenging aspect of this dimension because it involves a radical

shift in awareness. Partners from western cultures raised within a separate self perspective, often view relationships from an egoic attitude, the familiar 'what's in it for me' and are unaccustomed to reflecting on the implications of their actions for the relationship. Yet it is precisely the ongoing cultivation of the relational dimension that can move partners out of a focus on their individual agendas and into an investment in a mission larger than themselves. This is captured in the comments of the following couples:

Bill: She's not like me. I like to have everything figured out ahead of time…my ducks in a row. When I know what I'm up against then I can plan.

Janet: And I'm more likely to go with the flow. I hardly ever read directions…I like to make it up as I go along. We never realized that it was those differences that kept us bickering so much of the time. My way used to make him nuts but when our daughter got sick, we found out that it's better to work together than against each other. If we talk about ways to plan and let me not plan, we like each other better and even get more accomplished. We have to get away from our own agendas and try to get the other's point of view.

Bill: Yeah, things definitely go smoother in our relationship when we can do that.

Another couple, married 44 years, put it this way:

Sally: It really took me awhile to realize I could be myself and still be part of this marriage. In the early years, we never went anywhere alone-we were like joined at the hip. After awhile I realized I couldn't figure out whether something was his thought or what I thought.

John: That's for sure. I think I got to resenting her cause I thought she just always went along with me and after awhile I think I started losing respect.

Sally: Yeah, that's probably when we started talking about how that habit wasn't helping our relationship very much.

Sally and John highlight the way in which empathy and respect are connected to self/other and relationship awareness. The ability to be aware, to notice the thoughts, feelings and actions of self and others, are foundational to the capacity to empathize with and ultimately respect those responses. The following dialogue, from a couple married 35 years, reflects that capacity as well as how it was nurtured over the years:

Mary-Lou: Stan was probably like most men…..unconscious! I spent a lot of time repeating myself and feeling so angry that I wasn't being listened to.

Stan: I have to admit I was pretty out of it but in my defense, I was trying to get a business started, we had young kids and I was totally focused on making it all work. I know I was just into myself.

Mary-Lou: Then we went through a spell where I had strange medical problems that were pretty scary for awhile. I felt so terrified and vulnerable and kept telling him I didn't know how I could take care of the kids.

Stan: That must have woken me up cause finally I really got how my focus on me all the time didn't let me appreciate what she was going through. She'd have to feel alone!

Mary-Lou: The medical problems cleared up-thank god- but we made a big decision during that time and that was to make time every week to talk together about what bothers us, what scares us, what we're facing that week. I cannot tell you what a difference that has made. I know it is not always easy for Stan to figure out what he feels but I have so much respect for the fact that at least he tries. I always feel closer to him cause I get what he is going through more.

Stan: Yeah, I actually look forward to our times. We have talked through some tough stuff.

Mutual Engagement in Supported Vulnerability

As Mary-Lou and Stan describe, one of the most difficult tasks individuals face is to recognize their fears, anxieties, and vulnerabilities and then expose them to their partner. Socialized in a culture that promotes independence, men and women alike see it as a sign of strength to operate like the Energizer Bunny—deny the impact and keep forging ahead. Empathy and compassion for a partner may come easier than self-compassion but it is a fragile gift. Without a capacity for self-compassion, it is common to revert to shame, blame, or avoidance, particularly under stress. There is considerable evidence for the value of mutual and active engagement in the relationship (Johnson, 2008) and for relying on the other which recursively strengthens couple bonds (Beitin & Allen, 2005; Ben-David & Lavee, 1996). Yorgason et al. (2007) clearly identified resilient outcomes when couples discussed their weakness and vulnerabilities over time. Here is where the idea of shared vulnerability becomes so important. When partners know that their real strength resides in the shock-absorbing capacity of the "we," it may encourage them to embrace, rather than avoid challenges.

The debilitating effects of isolation and disconnection are reflected by the comments of a couple, married 27 years:

Becky: We had a series of things happen in our family…my sister had a Down's child, our daughter was diagnosed with ADHD, Sam's job got shaky and I felt so alone with all of it. Like I was the weak one, the crabby one, the one who should have but couldn't take it.

Sam: Yeah, I actually felt the same but even worse 'cause it was my fault my job might put our family at risk. But when she started to talk about how she felt, I felt more OK to talk about me. I had no idea what all was going on in her head and it was a relief to know how she felt. I could reassure her or do something instead of feeling helpless, responsible and scared, alone.

Creating Meaning for the Relationship

The scientific study of meaning has repeatedly demonstrated that people who believe their lives have meaning or purpose appear better off (King, Hicks, Krull, & Del Gaiso, 2006; Lyubomirsky, 2007). The creation of "meaning" (understanding

where we've been, where we are, and where we're going) is one of the most human and critical tasks we face and a vital part of resilience (Walsh, 2011). Furthermore, those who find meaning following adversity or traumatic life events report better outcomes than those who do not (Janoff-Bulman & Yopyk, 2004).

While these represent studies of individuals, a growing scholarship suggests that the co-creation of meaning, a unified framework for understanding an experience, can be important for couples. Couples who constructed a unified meaning for a cancer diagnosis (specifically defining it as "our problem") found that it lent coherence, provided direction, and helped them manage the accumulation of stressors and illness demands (Skerrett, 1998). Indeed, in sharing their couple story, Mark and Justine described the effect of an ovarian cancer diagnosis on their relationship. They described not only the salience of mutual meaning but the fluidity with which it changed and evolved over time:

Justine: I struggled for a long time with the 'why me?' issue; I just couldn't make sense of it and I desperately wanted to make some sense of the whole thing.

Mark: She was really hard to live with for awhile…nothing I said seemed to make a difference and we were going in different directions.

Justine: When I had a recurrence and he came to chemo treatments with me, we had long times to talk and eventually we realized the way to make sense of what was happening was to pull together. There was no magical reason I got cancer…it just happened and if we did not work together, I would go under. WE would go under.

Mark: After that, we really started to get some traction. The ugly 'why me' question comes up from time to time, but we ask it together and try to figure stuff out together and it really helps. It helps me anyway.

The Construction and Maintenance of Relational Positivity

Our couple stories were filled with vignettes of the central role that positivity played in relationship quality, particularly among the longer married. Most often, it was a combination of spontaneous gestures that arose from mutual caring and affection and the use of humor and light-hearted good fun. Less often, the positivity was a conscious effort to inject good will or appreciation or desire to 'lighten up.' Lois and Bill, married 24 years, comment:

Lois: I came from such a grim, negative family. No one ever said a kind word, or at least that is how it felt. Of course, you heard about it if you did something wrong! One of the things I love about Bill is that he can defuse even the most challenging conversations. He can find something funny or offbeat or just lighten the mood and it makes such a difference to our life together.

Bill: I have learned how being positive, gets you more positive and that is really cool! Over the years, she has gotten more positive herself and I sure get the feeling she appreciates me! That, all by itself, makes me feel better.

Their brief interchange also exemplifies the recent finding that expressions of positivity, especially gratitude, promote relationship maintenance in intimate bonds (Gordon, Impett, Kogan, Oneis, & Kelter, 2012).

Now at the forefront of the work of leading neuroscientists, positive emotion is being given a central role in the body's ability to galvanize change and guide healing (Fosha, Siegel, & Solomon, 2009). From the neuroanatomic to interpersonal levels, relationships form and nurture the self-regulatory circuits that enable emotions to enrich, rather than enslave, our lives. The influential broaden-and-build theory of Frederickson and her colleagues suggests that positive emotions: (1) broaden people's attention and thinking, (2) undo lingering negative emotional arousal, (3) fuel psychological resilience, (4) build consequential personal resources, and (5) trigger upward spirals toward greater well-being in the future (Fredrickson & Branigan, 2005; Fredrickson & Joiner, 2002). Fredrickson (2006, 2013) found that individuals who experienced more positive emotions were more likely to find positive meaning in stressful situations. She writes that as these effects of positive emotion accumulate and compound over time, they carry the capacity to transform individuals for the better, making them healthier and more socially integrated, knowledgeable, and effective.

This literature as applied to couples points to the importance of creating, a "culture of positivity" (Gottman & Gottman, 2005). If the relationship itself can be seen as a source of positive emotion, couples are more likely to view the relationship as an entity that nourishes, sustains, and is worthy of time and attention. Such a belief set and related expectations promote relational empowerment and confidence, qualities that exert a synergistic effect on marital interactions.

Reintegrations of Relational Wisdom

Neff and Brody's (2011) work suggests that skills- relational or otherwise, must be given the chance to become habit and stress inoculations early in married life can have a positive effect on coping over time. Our couple stories suggest that the habit of we-consciousness promoted such relational wisdom. Each time partners struggled with a challenge and experienced a positive outcome, it became a part of the relational arsenal – a talent that could be returned to and honed again and again.

Resilient reintegration means to experience some insight or wisdom through these accumulated disruptions (Richardson, 2002). It requires the ability to identify, access and then reinforce adaptive responses-all of which rely on reflective capacities. Recycling through such a process results in reinforcement and strengthening of individual and relational resilience and confers potential protection. The growth and development of a relationship depends on such repeated resilient reintegrations that arise from both planned and unplanned challenges.

The following conversation between a couple married 40 years, is exemplary:

Joann: Somehow, we learned early on that you have to keep talking to each other or it will not work. It is not like either one of us had particularly great role models

for parents….maybe we saw what we did not like and decided to do it different but we made this agreement with each other to keep talking and it has not failed us.

Eric: Yeah, you can bet that was not always easy for me. Lots of times, I preferred to keep my pissy mood to myself but the more I (usually Joann) pushed me, the easier it got and I realized that staying on top of stuff really made a difference between us. It gives me a sense that we are a team and that she cares about me, no matter what.

Joanne: It really paid off when our son was sick, when Eric had a scare with his heart, when my brother died suddenly….by then, we had this habit of talking things out and it really kept us sane.

Eric: and together!

It is the narrative movement from emotional conflict to an end point of caring that elevates their particular story from simply a couple story to a we-story. Becoming aware of the various ways in which that happened became their relational wisdom. This is reminiscent of the work that identifies that the lessons narrators draw in telling a story (life lessons) are particularly associated with better adaptation and greater emotional maturity (Blagov & Singer, 2004). More vivid, positive and well-rehearsed favored stories are linked to greater levels of marital satisfaction (Alea & Vick, 2010). In addition, the sharing of more personally significant relationship memories (especially for women) produced greater intimacy among couples (Alea & Bluck, 2007).

Our stories suggest that the development of a we perspective is the epitome of relational wisdom. The capacity to craft and maintain a mindset of mutuality involves capacities for self reflection, attunement to self and other, the interpretation of rules and principles in light of the uniqueness of each situation, and the ability to balance conflicting aims. We suggest it to be the master virtue of relationship development, related to virtues of knowledge, curiosity, generosity, gratitude, compassion, built through mastering adversity, and cultivated across the lifespan of the partnership. These capacities are developed through dialogue such that the resulting story of an us or 'we-story' becomes a touchstone to what is most vital and precious in the relationship. It is this wisdom that can be passed forward to the generations that follow (Singer & Skerrett, 2014).

We propose that it is the synergistic dynamic of all the components of relational resilience that gives couples the distance and objectivity necessary to cope with ongoing challenges. The stressor, whatever it is, becomes disembodied from either partner and their we-ness becomes the source of relational resilience. It is not just about me or what is happening to me, but rather to "us" and the relational coping responses have different potential than either individual's alone. Particularly because our relational schemas are prone to disruption under stress, having a clear and operational awareness of the "we," equates with the resilience potential available to partners. The "we" functions as an umbrella both sheltering and all encompassing, with regular input from each partner to recursively inform and shape the "we."

Suggestions for Future Research

A key limitation to the Couple Story Project research cited here is the relatively homogenous nature of couples examined. While we have and continue to expand story collection to a more diverse population, couples primarily represent white, educated, well-functioning partnerships. Plans are underway to continue to expand to a broader range of socioeconomic, ethnic and gender diversity.

Proposed next steps would include an examination of the various pathways to we-ness as well as the identification of other relationship attributes associated with strong states of "we." Might this vary by gender and does we-ness confer particular protective advantages for women or men?

We-ness should also be examined within various complex contexts involving multiple stressors. How might the mutuality of we-ness impact couples struggling with both chronic health conditions and multiple situational challenges? It would also be important to look at partner ability to cultivate and sustain we-ness under a variety of circumstances, for example the sudden vs. gradual onset of challenges or challenges that were solicited vs. those that were uninvited.

Research studies that are longitudinal and multi-method in design and follow couple resilience patterns across the life cycle would be ideal. Such designs would allow us to map out the specifics of what constitutes resilient outcomes for particular kinds of couples at particular points in time. Couples could be recruited who identified themselves as "strong" or well-functioning and could be our co-theoreticians in these foundational stages.

Implications for Relationship Enhancement and Therapy

These ideas represent a framework of positive, optimal couple functioning that attempts to locate the components of relational resilience within the relationship itself. Couple resilience is proposed to have a major role in relationship enhancement, assessment, and may suggest guidelines for couples in distress. Assessment of couple functioning is crucial, both to identify where in the resilience distribution a couple falls as well as to develop data sets of couple profiles.

Clinical work with couples reinforces the essential nature of self, other, and relationship awareness for change. ATUNE interventions (awareness, tolerance, understanding, non-defensive listening, and empathy) utilize comparable building blocks and propose similar elements as necessary to cultivate couple intimacy, friendship, positive affect, and shared meaning (Gottman & Gottman, 2005). Similarly, moving couples toward a COAL state (curious, open, accepting, and loving), promotes movement into a visceral, mutual state of regulation and that sweet spot of optimal brain plasticity (Siegel, 2006).

Since couples present for therapy in distress, it is unlikely that they are focused on the resilient qualities of their relationship. Some couples may never have considered

the idea. Paramount is the ongoing education of couples regarding the primacy of their relationship – that it is the cultivation of "we-ness" that operates as the safety and security system for both. They are in the care of one another. Without that understanding, neither can thrive. Helping couples to jointly focus on that third entity, their relationship, builds secure functioning and promotes the capacity to mutually amplify positive moments between one another. Gradually beginning to shift couple sights to their assets and strengths infuses the climate of the therapy with positivity, hope, and potential. For example, Sheila and Jim were a couple in their late thirties who were seeking therapy to help them co-parent their young children with less conflict. The individual online evaluations they completed (www.authentichappiness.org) indicated Sheila's lead strengths as curiosity, persistence, and kindness and Jim's as love of learning, creativity, and persistence. They were able to see how they could mobilize all of those assets, particularly love of learning, curiosity, and persistence to join together in building a joint platform that would provide options when they became polarized or deadlocked around a parenting issue.

The reflexivity component-building couple consciousness of the "we" is both challenging and essential. Since earlier research identified that optimal couple functioning depended on the ability of both members of the couple to define a challenging experience as "our problem" (Skerrett, 1998, 2003, 2010, 2013), several therapeutic techniques have shown promise in helping couples develop a "we" awareness. Teaching couples about the differences in self, other awareness, and their relationship not only from the earliest encounters but throughout therapy is vital. Pointing out the stories they have constructed around the challenge they face is a first step toward helping them re-craft more positive outcomes and expand their coping repertoire. Sheila and Jim had developed a story that they were "ineffective, stupid parents" who could never agree on what was best for their children and bound to conflict. A contributing storyline was that Sheila, as the fulltime parent, knew best how to discipline and relate to the children and that Jim should agree with and always support her decisions. They each had a tendency to stockpile resentments until one or the other "blew" which only further supported their mutual belief that they were "bad communicators." They could easily see that such meaning-making left little room for mutual empathy, understanding, compromise, or a successful outcome.

In contrast, the story of Susan and Brad offers a very brief illustration of the ways in which the elements of relational resilience can be worked with in therapy. Susan was a 59-year-old accountant who came to therapy for help with increasing feelings of sadness, despair about her 30-year marriage, and a sense of being imprisoned by the demands of work, family, and life in general. A diabetic previously struggling with numerous complications, she had been successfully stabilized and pronounced healthy by her doctor. She described feeling mystified as to why, in the face of such good news, she was so miserable. A driven perfectionist all her life, she knew she needed to modify her over functioning but could not seem to interrupt old habits. The self, other, and relationship awareness teaching began immediately with coaching on a strategy to invite her husband to join us. Brad told a story of similar levels of frustration, feeling "cut off" by Susan and not loved in the old ways even

after he had been supportive and attentive during her chronic and difficult health crises. He no longer felt needed by her and had "no clue" how to get her attention anymore. A successful accountant himself, he believed himself to be slipping into depression, gaining none of the usual pleasure he obtained from work, sports, or contact with their three adult children. They both agreed that if they did not redefine and revitalize their relationship, they doubted they would continue together.

They learned that in order to begin the challenging work of revitalizing their relationship, both would need to feel that they had a voice and that both would need to risk becoming reinvested in the relationship. Teaching essential brain basics oriented them away from blame and shame and toward their shared human biological nature. Our work revolved around building awareness of and compassion for the acute vulnerabilities expressed in one another's innate wiring and expressed in story form. As they shared the story of their meeting and early years together, we identified qualities of the relationship (we-awareness) they had developed that they summarized as "hard working teammates." They were coached to regularly notice the relationship outside of sessions and ask the questions: "Is it working right now? What am I doing that is contributing to where we are at?" They were reminded that they were responsible to bring only their self-awareness to the other and were not responsible for the thoughts, feelings, or behavior of their partner. This promoted the mutual ability to approach challenges from the question of "what do I need to learn to help us better function as a team"? Sessions were infused with techniques and homework to increase positivity such as individual and couple journaling (Niederhoffer & Pennebaker, 2009), everyday acts of caring (Lyubomirsky, 2007), gifts of gratitude (Emmons & McCullough, 2003), and positive re-storying (Singer & Skerrett, 2014; Skerrett, 2010).

Building from an earlier foundation of empathic knowing and the capacity for mutuality, we were able to identify together the ways in which they had gotten off track with one another and how they had begun to view the relationship as a problem rather than a resource for change. Gradually, as they came to understand the necessity for mutual compassion, responsibility, and re-engagement in the relationship, they began to report renewed energy and interest in one another. They worked together to craft a current vision for the relationship that they titled "caretaking teammates."

Conclusions

It is recommended that resilience be examined and explained as a couple phenomenon and a dynamic process qualitatively different than the combination of individual partner resilience. Drawing from Walsh (2011) and Jordan's (1992) identification of empathic reciprocity as the key to relational resilience, we have offered the concept of we-ness as the unique dynamic that characterizes couple resilience. Such a perspective may help to explain why, under the same conditions, some couples are resilient and others are not. It also allows us to examine whether the capacity for we-ness contributes to individual partner and couple stability and growth.

What remains is the complex work of systematically investigating each of the processes; identifying how they interrelate and which, if any, most contribute to optimal individual and couple resilience. For example, is the capacity for mutual empathy or the ability to activate positive skill sets more critical for we-ness and relational resilience? What kind and how much practice in the teamwork of we-ness is necessary? Can this best be taught through relationship education or through the long term 'school of hard-knocks'?

It is also crucial to identify the various indicators for treatment and intervention, as opposed to resilience promotion. If certain kinds of adversities in the lives of couples result in a natural return to pre-challenge states, intervention may prove to be contra-indicated. Likewise, relationship enhancement programs would be directed toward those circumstances that prove most amenable to change and growth.

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Chapter 2
Theoretical and Methodological Underpinnings of Resilience in Couples: Locating the 'We'

Karen Fergus

In the previous chapter, Skerrett demonstrates how relationship resilience is founded upon the couple's mutual self-sense or 'we-ness.' In this chapter, I examine this phenomenon from the opposite end – that is, what is it about we-ness that promotes resilient adaptation by couples? I propose that the 'we' may even in itself be considered an expression of resilience in the way that it maintains, expands and differentiates across time and experience. The *we* would not *be* if not for the capacity to weather the storms of loss, crisis, chronic stress, and major life transition. Such challenges in turn, when dealt with successfully, endow the relationship with a tensile strength or hardiness – even vigor – further preparing it for stressful yet unknown times to come. Resilience in this sense is the result of a spiraling interplay between adversity and relational resources with the couple's we-ness figuring as 'resilience in the raw' if you will, or as the relational essence (Reid & Ahmad, 2015) that precedes, and is brought to bear upon, the particulars of any given hardship.

As integral as we-ness is to couple adaptation, it is also highly elusive. Josselson (1994) indicates that of all the dimensions comprising relatedness "this sense of 'us'… is the hardest to talk about, partly because it exists so completely between selves" (p. 97). Finding ways to tap this interstitial third entity then becomes the challenge for academics and clinicians alike. Although post-modern perspectives on the nature of the self have successfully challenged the assumption of a monadic 'I' that is bounded and contained, the study of the individual nonetheless continues to profit from the clarity and relative simplicity afforded by persons being skin-bound. The study of couples in contrast, and specifically partners' unified self-sense and their corresponding collective identity, does not have as concrete or defined a place upon which to stand and launch itself. My intention here is to present two promising platforms for the examination of 'we-ness' corresponding broadly with the style and

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content of couple communication – one linguistic, emphasizing language and pronoun usage, and the other storied, emphasizing partners' co-construction of shared meaning and the narratives they live and often tell. Whereas the former 'points at' the partners' shared affiliation, the latter is a substantive expression of the unique life-world that partners co-create and inhabit. As much of my work as a clinician and researcher centers on the impact of cancer on intimate relationships, I draw heavily on this background when offering examples intended to concretize abstract concepts.

Intersubectivity theory (Crossley, 1996) and dialogic dialectics (Baxter & Montgomery, 2000; Montgomery & Baxter, 1998) form the basis for this discussion. Both frameworks assert that communication between individuals (intimates in this case) functions as the substrate for the 'we.' We-ness is evident in 'our' talk and the couple's idiomatic vocabulary including the subliminal linguistic choices partners make; it is lived through and captured by story and the memories partners share; it anchors partners' experience of personal identity affording a sense of assurance about oneself and the world; and it is infused with intricate, highly idiosyncratic self-other knowledge and mutual attunement. All aspects are expressions of partner intersubjectivity and, as I hope to demonstrate, foundational if not fundamental to couple resilience.

We-ness as the Interstitial 'Third'

A long-term intimate relationship entails a dynamic interweaving of selves in which the individual experience of self is altered, enhanced, constrained, and buttressed by virtue of partners' continuous mutual engagement with one another (Berger & Kellner, 1964). Baxter and Montgomery (1996) maintain that the closeness of a relationship may be determined by the extent to which the 'self becomes' or changes through participation in that relationship, suggesting that boundaries between 'self' and 'other' are more permeable and fluid in a close, intimate relationship. To the extent that personal identity is fundamentally social (Gergen, 1987; Mead, 1934), perhaps nowhere is identity formation so pronounced as within the crucible of a longstanding intimate relationship. By the same token, intimate partners are continuously shaping the relationship they reside within thus defining, while being defined by, their unique "micro-culture" (Baxter, 1987a). 'We-ness' may therefore be understood as "relationship partners' often non-conscious participation in a highly implicit collective reality that is both shaped by, and integral to, the personal identity of each member of the couple" (Fergus & Reid, 2001, p. 387). Not surprisingly, this collective sense of an 'us' appears to grow stronger with time and age with older couples demonstrating greater levels of we-ness than couples at middle-age (Seider, Hirschberger, Nelson, & Levenson, 2009).

This blending of relationship partner identity has been construed as a type of cognitive closeness in the social psychology and relationship science literatures. The theory of cognitive interdependence proposes that a person's self-representation

becomes pluralistic and collective in direct correspondence with a deepening of commitment to the other and the relationship, to the point that one's sense of self is rendered inextricable from "self-in-relationship" (Agnew, Van Lange, Rusbult, & Langston, 1998). Similarly, Aron and Aron (1986) maintain that love entails an "expansion of self" whereby individuals are rewarded through their participation in relationships because of the perceived ability to expand the bounds of oneself through another's resources, perspectives, and characteristics. This supposition has been supported by a series of experiments demonstrating how "cognition about the other in a close relationship is cognition in which the other is treated as self" to a greater degree than cognitions concerning people of lesser personal significance (Aron, Aron, Tudor, & Nelson, 1991, p. 242). The 'we' is therefore apparent in how spouses conceive of themselves, one another, and the relationship. To experience a sense of pride in a spouse's accomplishment, for example, in which one feels almost as uplifted as the spouse him or herself does over having achieved a long-term goal, is a reflection of such cognitive closeness. In a different vein, to feel the pain of a spouse's loss as though it were one's own, as in losing a breast to breast cancer, or losing one's libido as a result of hormonal treatment for prostate cancer, is similarly indicative of the extent to which the self has expanded to include the other.

A common assumption underlying discussions of the I-we interface is that the more individuated or differentiated the 'I' is, the more flexible and adaptive the 'we' will be (Bowen, 1978; Karpel, 1976). In other words, the well-being of the relationship rests on respective partners' capacity for both intimacy and autonomy and the ability to strike an integrated balance between the two. To do so results in a we that is 'differentiated' rather than 'fused' (Karpel, 1976). A couple's experience of mutuality, for instance, depends on partners' negotiating their individual needs in ways that acknowledge and prioritize the needs of the other and the relationship (Singer, Alea, Labunko Messier, & Baddeley, 2015). It has been suggested that a differentiated we, while secure and predictable in one sense, will also exhibit greater responsiveness and flexibility in relation to change (Karpel, 1976; Minuchin, 1974), an assumption with clear implications for couple resilience.

In one study, differentiation of self (i.e., the ability to maintain a sense of self and self-regulate within a close, interpersonal relationship) was positively associated with marital adjustment for both male and female partners (Skowron, 2000). Self-differentiation has been further related on a conceptual level to "Power To" which includes the ability to self-soothe or self-regulate strong emotions particularly in times of conflict or tension, and as such, is considered essential to the experience of "relational empowerment" along with the capacity to experience "Power With" in the form of mutual respect and empathy (Fishbane, 2011). Interestingly, self-differentiation and the corresponding recognition of the other's *otherness*, has also been linked to the experience of lasting sexual satisfaction and eroticism in couples (Perel, 2006). What's crucial however, especially from a Western individualistic standpoint, is to resist granting primacy to differentiation over fusion; rather, from a dialogical perspective, relationship vitality depends on the ongoing dialectical dance between the 'we' and the 'me' (Baxter, 1990, 1993), between unity and difference (Baxter & Montgomery, 2000).

Yet for as strong and capable as a differentiated we is, it nonetheless remains elusive and mercurial. In reference to Buber's (1958) concept of the I-Thou relationship, Crossley (1996) speaks to the "irreducibility" of mutual engagement and, in so doing, helps to clarify why we-ness is so difficult to locate:

> Such a situation is meaningful and thoughtful but the meanings and thoughts that it entails are strictly irreducible to either participant. They are formed in and belong to the interworld which forms between them. Moreover, each participant is decentred in relation to the joint situation. Their thoughts and experiences are dialogically interwoven with those of their other. (p. 12)

Couples themselves are often rendered momentarily speechless when asked directly what they mean by 'we' or 'us.' As one spouse expressed, "It's very hard to put into words. I guess after 34 years of marriage, you are a very close entity. It's a unit, not an individual type thing." Another responded by describing herself and her husband as "…a pair, a couple, intertwined together. That's the we" (Fergus, 2011, p. 104). Indeed the metaphor of interlacing strands forming a durable fabric or intricate tapestry is offered time and again in couples' descriptions of their unity. This braiding of selves results in a relationship that is both greater than, and inextricable from, the two individuals comprising it. It is in reference to the complexity and embeddedness of relationships that Josselson (1994) claims so rightly, we are "doomed to imprecision when we stray into the realm of communion" (p. 83). Furthermore, the automaticity and lack of reflective consciousness with which this intermingling occurs cannot be sufficiently emphasized (Berger & Kellner, 1964). Relational schema, interpersonal scripts, emotional signaling and the like provide quick routes to interaction enabling relationships to unfold and maintain without much awareness or forethought (Baxter, 1987b; Burnett, 1987). It is conceivable, then, that in order for relationships to grow and improve, or adapt to changing circumstances, individual partners must enlist their reflexive faculties – that is, to step back and reflect upon self, other, and 'us' in relation to each challenge as it unfolds within, or before, the couple (Fergus & Reid, 2001; Reid & Ahmad, 2015; Reid, Dalton, Laderoute, Doell, & Nguyen, 2006).

We-ness and Resilience

There is a growing consensus among relationship researchers and clinicians that relationships may be improved by enlisting the couple equivalent to the 'observing ego' (Glickhauf-Hughes, Wells, & Chance, 1996; Reid & Ahmad, 2015; Reid et al., 2006; Wile, 2002). Drawing on William James's (1890/1950) famous distinction between the subjective, experiencing 'I' and the objectified 'me,' intimate partners have the capacity to engage in a similar form of reflexivity whereby the conjoined 'we' steps back and gives thought to the unified 'us.' Such relationship awareness as defined by Acitelli (1993) entails an individual's thinking about the patterns and interactions in the relationship as well as partners' respective thoughts and feelings, and includes consideration of the relationship as a whole (p. 151). This process

occurs most readily in contexts where partners' respective 'I's feel safe and secure (Fishbane, 2011). However, it has also been suggested that the very process of reflecting upon the relationship in this way, is in itself a means by which relationship schisms may be bridged (Fergus & Reid, 2001; Reid et al., 2006). The couple's ability to reflect and conjointly objectify when applied to external stressors is also instrumental to couple resilience – a point I will return to later. Moreover, there is emerging evidence that one's tendency to be mindful in the moment is associated with general relationship satisfaction as well as the capacity for partner empathy and perspective taking (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007; Burpee & Langer, 2005; Kozlowski, 2012; Wachs & Cordova, 2007) bearing clinical implications for enhancing relationship interactions (and the corresponding neurocircuitry) through mindfulness training (Atkinson, 2013, 2015).

Giving the relationship thought and attention, that is "minding the relationship," has been associated with enhanced closeness and marital stability in daily life (Harvey, Pauwels, & Zickmund, 2005), but what accounts for the common observation that relationships are often, like people, strengthened in the wake of more extreme, troubling conditions? As Walsh (1996) contends, "resilience is forged through adversity, not despite it" (p. 7). According to Richardson (2002), such strengthening is the result of a succession of lifelong "resilient re-integrations" whereby the individual accumulates more knowledge and know how with every situation that challenges normative functioning. Such disruptions, both "planned and reactive," (Richardson, 2002, p. 313) spur resilient reintegrations that, in turn, lead to growth and adaptation rather than simply recovery and re-equilibration. This point echoes Walsh's (2003) framing of resilience as "bouncing forward" rather than the more common metaphor of bouncing *back*, as well as Lepore and Revenson's (2006) concept of "reconfiguration" as one type of resilience along with "resistance" and "recovery" – with reconfiguration referencing the capacity to emerge from difficult circumstances more strong and resourceful than before. In other words, resilient adaptation leaves a constructive imprint and that imprint is carried forward.

The process of resilient reintegration at the level of the couple underlies the development of "relational wisdom" (Skerrett, 2015). Resilience in couples has been attributed to a type of practice effect in which experience with past adversities prepares partners for future ones (Neff & Broady, 2011). In one study of couples' transition to parenthood, it was found that experience with *moderately* stressful life events, combined with observed support-seeking behavior on the part of both spouses earlier in the marriage, predicted greater self-reported relationship adjustment shortly after the birth of a first child (Neff & Broady). Too much stress, however, may have the opposite outcome creating a "spillover" effect that is detrimental for couples (Neff & Karney, 2009). The latter finding speaks to the importance of having time and opportunity for *integration* or assimilation as a necessarily prelude to resilient *re*integration. Too much stress or change and not enough stability may be a risk factor for couples. An accumulation of stressors such as one partner's threatened job security or eventual job loss, combined with the other partner's chronic autoimmune disease and/or pain, as well as increasingly dependent aging

parents, and one teenager's withdrawal or hostility within the family system – could be one such constellation of factors that tip the scales from resilient reintegration to disintegration and possible dissolution, even in the strongest of marriages.

I-We Identity Processes and Resilient Adaptation

There are a number of processes specifically related to we-ness that are instrumental to couple resilience. While those more overt expressions of couple intersubjectivity are examined in greater detail below, there are a few processes related to identity formation – both shared and reciprocal – that bear mentioning at this juncture. This discussion is particularly relevant to stressors that affect relationship partners unevenly. That is, where one member of the pair is directly impacted by the stressful occurrence or circumstance, and the other is, by default, cast in a supporting role such as in the case of illness or injury. This discussion is based on the premise that when individuals feel strong in their relationships, they feel strong in themselves and thus more equipped to withstand challenging situations.

Owing to the "communal" character of close relationships in which partner give-and-take is determined on the basis of need, not exchange (Clark & Mills, 1979, 2012), partners will tend not to feel under-benefited in the relationship despite apparent inequities in the exchange of support when, for example, one partner is physically impaired (Kuijer, Buunk, & Ybema, 2001). The resulting transformation of motivation from one of self-interest to one which favors the other's interests and/or those of the relationship (Agnew et al., 1998; Rusbult, Wieselquist, Foster, & Witcher, 1999) in part accounts for how the needs of the more vulnerable spouse tend to become naturally centralized in resilient couples during times of acute stress or crisis. Of course less tangible yet universal experiences such as love and compassion also need to be recognized in discussions of pro-social behavior between partners.

From the standpoint of the self-expansion model of love (Aron & Aron, 1986), allocation of personal resources becomes communal in close relationships because "benefitting other is benefitting self" (Aron et al., 1991, p. 242). In other words, owing to the myriad of ways in which self and other merge in communal relationships, a well-spouse's helping behaviors toward an ill or impaired partner effectively function to support the spouse as well. In this sense, caring for an intimate other is unlike caregiving for any other individual because not only has the self in relationship expanded by including the intimate other, but the other has become included in oneself. Therefore, caring for the other and ensuring the other's well being is, to some degree, *caring for self*. From a cognitive closeness perspective, there is an element of self-care built into caring for one's partner, and this blending of personal and communal motivation contributes to the resilient adaptation of the collective.

Another identity-related source of strength in couples has to do with the ways in which intimate partners assume a vital role in validating one another's sense of self

(Berger & Kellner, 1964). It is through "eye to eye validation" that we become real to ourselves and we feel most secure in ourselves when we are able to ascertain "what we mean, and that we mean for others" (Josselson, 1994, p. 94). It has been demonstrated, for example, that affirmation by one's partner that is in keeping with one's own self-ideal, is associated with better relationship adjustment and stability (Drigotas, Rusbult, Wieselquist, & Whitton, 1999). Moreover, if a spouse's positive view of his or her mate is more favorable than the mate's own view, and if the spouse tries to stabilize such positive impressions then, over time, the person's negative self-view could begin to change for the better (De La Ronde & Swann, 1998). Thus to the extent that traumatic life events or major life transitions such as retirement significantly challenge or disrupt one's personhood, spouses have a crucial role to play, by virtue of their identity supporting function, in facilitating the affected partner's process of constructive self-redefinition.

Related to the bolstering of the more vulnerable partner's identity is the intricate self-other knowledge intimate partners possess of one another. That is, the capacity to respond to one's partner in an appropriately supportive manner is predicated on this implicit relationship knowledge (Gottman, 1999) as well as on accurate empathy for the other (Ickes & Simpson, 1997). Perceiving one's partner as responsive to one's needs, goals, values and so forth has generally been associated with greater relationship satisfaction and personal well-being (Reis, 2013). The concomitant experience of feeling validated, understood and cared for (Reis & Shaver, 1988) would arguably be that much more imperative when one partner is in distress. Such responsiveness entails the ability "to discern non-verbal cues, and to 'read between the lines' about motivations, emotions, and experiences," (Harvey et al., 2005, p. 424) what Harvey and colleagues term, "knowing and being known." Being attuned and responsive to non-verbal and para-verbal cues, in turn, is conducive to couple coping because it enables well spouses to be appropriately supportive *without having to be explicitly directed or asked*. The intersubjective dance of signaling and responding in this manner has implications for identity maintenance. A man recovering from prostate surgery and struggling with the prospect of incontinence, for example, may find it difficult to ask directly for help with cleaning his catheter. However, his partner's attuned responsiveness to his unexpressed practical need helps to preserve what little sense of self-sufficiency he might be experiencing in that moment (Fergus, 2011). An intimate partner therefore provides a highly customized form of support, one that is deeply rooted in the pair's intersubjectivity and has a critical role to play in couple resilience by virtue of the identity maintenance function he or she enacts.

We-ness as an Intersubjective Process

The main premise of intersubjectivity theory is that relationships entail "interacting subjectivities" comprised of "reciprocally interacting worlds of experience" (Stolorow, Atwood & Brandshaft, 1994, p. x). Within an intersubjective framework,

there is a movement away from intrapsychic formulations of self and mind, to one that is interpersonal and contextual (Stolorow, 1994). Drawing on the theories of (Buber, 1958; Husserl, 1960; Crossley, 1996) proposes two types of intersubjectivity respectively: *Radical* intersubjectivity based on Buber's notion of the I-Thou relationship, and *Egological* intersubjectivity based on Husserl's phenomenology. Radical intersubjectivity entails a type of "communicative openness" (p. 23) and non-reflexive merger with the other whereby 'self' and 'other' essentially dissolve in that moment. Egological intersubjectivity, on the other hand, entails the experience of separate I subjects who are able to bridge their divide through empathic relating, which is in turn, dependent on the imagination. The other is experienced via an "…imaginative transposition of self into the position of the other" (p. 23). For Crossley, intersubjectivity enlists both forms of engagement loosely corresponding with non self-conscious immersion (in the radical sense) and reflective awareness of the other and the interaction (in the egological sense). To dialogue with another involves continually shifting in and out of, and in between, the two modes. The resulting "interworld" that unfolds through dialogue is therefore irreducible to any individual; that is, the shared situation transcends its respective participants while remaining inclusive of them.

Below are some examples offered in an attempt to clarify further the difference between the two modalities – the first being a scene depicting egological engagement:

When two acquaintances meet by chance, there is a question of whether the conversation will continue beyond the initial greeting. The two participants may at first find themselves standing 'outside' of the conversation, perhaps thinking of the last time they spoke, or remembering that something significant has occurred for the other since their last encounter, such as the birth of a grandchild. They may also be wondering whether the conversation will continue for much longer beyond the exchange of pleasantries. Within this mode, the individual is, in a sense, entering into the world of the other through a process of remembering and imaginative inference. He or she is also reflecting on the life of the conversation itself – or on the other, and/or, on oneself. Whether reflecting, remembering, or empathically imagining, there is an implicit sense of a separation between the two parties (not withstanding the attendant willingness to close this gap in the discursive moment). Such is egological intersubjectivity where the 'I' and 'you' remain distinct and intact despite the bridging of two people through the dialogical interchange.

Contrast the previous scenario with that of two intimate partners' greeting each other at home at the end of a workday. They might discuss some highlights of the day – an interaction with a boss or co-worker, what they did over lunch, a report they submitted for review etcetera. Each might imagine the other earlier in the day, and possibly attempt to grasp empathically what the other might have been experiencing in a given moment or context. Very quickly however, they slip into a more radical form of intersubjectivity – where they start to communicate in shorthand about a shared frustration with one of their children, or about a television show they are both excited to watch after dinner referencing their favorite line from the last episode. Or perhaps this conversation never had a chance to get off the ground

because one partner, Sarah, is feeling agitated and preoccupied and thus unopen to the conversation. Robert, in turn, quietly yet non-defensively disengages from the conversation and leaves the room – picking up perhaps unconsciously on Sarah's closed state. Sometime later, Sarah, having recognized that she shut Robert out by failing to respond in kind to his attempt to connect, attempts to mend the small tear between them – through an affectionate touch, or perhaps an apology and accompanying overt recognition of the earlier displaced emotion and the impact it might have had on him. Some of the nuance and subtlety of these forms of communication would be lost to an 'outsider' witnessing the scene because that person would be more restricted in his or her ability to "enter into" this interaction having mainly at his or her disposal, a more egological mode of relating to it. Moreover, that shared 'headspace' (or better, mind-body-feeling space) is one where the alterity of the other, if apprehended at all, is barely visible. The partners are immersed and embedded, one within the other; their respective experiences are intertwined and overlapping and as such cannot be teased apart (Crossley, 1996). The meta-awareness of being 'in conversation' is also backgrounded to the point of being scarcely perceptible. Such is intersubjectivity in the radical sense.

These examples are not intended to imply that egological and radical intersubjective states are the exclusive domain of acquaintances and intimates respectively. On the contrary, according to Crossley, there is often a shifting between modes occurring in all forms of discourse regardless of degree of closeness between participants. I would maintain, however, that the intersubjective interworld Crossley references is exceedingly more textured and layered in the context of an intimate relationship owing to the pair's shared history, interdependency, and overlapping identity. Nevertheless, Crossley's description helps to elucidate the radical-egological back-and-forth common to conversational interaction:

> Sometimes we are deeply engrossed in others, too engaged to be aware of either ourselves or of them. At other times, and rapidly, we become sharply aware of both, constituting them as reflective and reflexive aspects of experience. All spontaneous interactions can be stultified by a reflective block, only to be undermined later by a genuine and spontaneous communication which collapses the reflective barriers of self and other. I's push their me's to the side and become joined. (p. 71)

Both forms of intersubjectivity have a role to play in couple resilience, and in my view, distinct ones at that. On the one hand, that capacity to know deeply the other and to be aware of and attuned to the needs and vulnerabilities of the other, and the capacity to 'be with' in a way that is open, validating, and loving *is* a radical form of engagement. Such I-thou relating – when achieved – might be considered the bedrock of the couple's mutual support structure. On the other hand, for partners to step outside of that communal form of engagement and, in an egological sense, enlist their reflexive faculties enables them to individually or conjointly consider one another and the stressor being faced. This capacity is necessary in order to discern how best to help the other in the moment, or cooperatively problem solve. The ability to reflect together is a double-barreled strength in that not only might it lead to salubrious outcomes, but it is indirectly reinforcing of the 'we' – a point that I will return to shortly.

According to Crossley (1996) dialogue is the means by which individuals transcend their separateness. In keeping with this notion, intimate relationships are forged through an ongoing dialogical interchange or "marital conversation" (Berger & Kellner, 1964). And like the relationship itself, the communication it is founded upon continuously evolves at the edge of competing dialectical forces (Montgomery & Baxter, 1998). For one, both fusion *and* separation are necessary in order for this conversation to occur (Baxter & Montgomery, 2000; Hermans, Kempen, & Van Loon, 1992) because two respective subjects (and corresponding subjectivities) are the pillars propping up a shared understanding. In reference to the following quote by Voloshinov (1973), Baxter and Montgomery (2000) outline three additional contradictions specific to relational dialogues: "Each and every word expresses the 'one' in relation to the 'other'… A word is a bridge thrown between myself and another" (p. 86 as cited in Baxter & Montgomery, 2000). These discursive tensions include: (1) that which is 'said' in and through language, versus the 'unsaid' which is implied based on context; (2) the constraint imposed by existing or inherited meaning, versus the freedom associated with new meanings that arise through the interaction; and (3) 'inner' versus 'outer' speech distinguished on the basis of personal as compared to explicitly social meaning.

Not only does this ongoing dialogue serve a crucial function in terms of the identity-formation and identity-preservation of each partner, but it also affirms and reifies the couple's subjective experience of the world between and around them. In other words, it is by means of this unending string of conversation between intimates, that a sense of stability and coherence are knit. According to Berger and Kellner (1964), partners' continuous intersubjective engagement and the dominance of the conjugal conversation, eventuates in the creation of a shared construction of one another and the world, one which, over time, becomes "objectivated" and solidified (p. 170). They go on to stress that, "The process (is)… one in which reality is crystalized, narrowed and stabilized. Ambivalences are converted into certainties. Typifications of self and others become settled…" (p.175). And as partners' feet touch solid ground each step of the way, they derive a sense of security in themselves and the world about them. A long-term relationship therefore functions as a vehicle for satisfying the basic human need for stability and coherence (Epstein, 1990). Spouses possessing a stronger sense of coherence (i.e., who experience of the world as comprehensible, manageable and meaningful) are expected to reorganize more adaptively following a crisis in the family (Antonovsky and Sourani 1988).

Both the content and structure of couple discourse are revealing of partners' intersubjective processes and as such, have received increasing attention in the study of relationships. This growing body of work spans research into marital satisfaction and therapy outcome, as well as couple adjustment to challenging life events such as a health crisis in one partner. Before turning to the content dimension of couple communication and specifically the shared narrativization process underlying mutual identity construction, I discuss the structural linguistic analysis of couple discourse in general, and later, its relevance to couple adaptation.

We-Talk and Couple Resilience

In terms of the structural aspects of conjoint communication, much of this research has focused on linguistic indicators and specifically, first person plural pronoun usage – that is, 'we' talk between intimates, as well as we-talk relative to 'I' and 'you' talk. Such surface features of language are considered significant in the way they reference or 'point to' each partner's identification with the other and the relationship they share (Pennebaker, Mehl, & Niederhoffer, 2003, p. 567). An assumption here is that the interaction between degree of pronoun inclusiveness, and the type of personal pronoun used (first or second person), carries meaningful information about the relationship. In fact, because pronoun usage generally occurs spontaneously and outside of the speaker's conscious awareness or volition, it is potentially even *more* revealing of the state of the couple's union than the content words such particles link together.

The evidence supporting the correlation between communally oriented language (or lack of) and relationship satisfaction has been steadily accumulating. In one textual analysis of couple conversations where cardiovascular arousal was measured during the interaction, we-words were related to lower autonomic arousal and more positive emotional behavior, whereas I-talk was associated with reduced relationship satisfaction and negative interpersonal behavior (Seider et al., 2009). These findings are consistent with another investigation in which we pronouns were correlated with greater observed positivity and lower observed negativity in problem focused discussions (Williams-Baucom, Atkins, Sevier, Eldridge, & Christensen, 2010). We language has also been positively associated with greater commitment (Agnew et al., 1998), and to marital satisfaction in older couples suggesting that interdependence of identity becomes stronger with age (Seider et al.; Sillars, Shellen, McIntosh, & Pomegranate, 1997). It should be noted, however, that *asymmetric* use of we-talk on the part of well-partners relative to patients while discussing health-related areas of disagreement, was associated with greater demand-withdraw conflictual communication (Rentscher et al., 2013). Findings pertaining to the use of second-person pronouns have been particularly robust in that 'you' talk is consistently associated with lower relationship satisfaction (e.g., Robbins, Mehl, Smith, & Weihs, 2013; Sillars et al., 1997; Slatcher, Vazire & Pennebaker, 2008) and negative martial interaction (e.g., Rentscher et al., 2013; Simmons, Gordon & Chambless, 2005; Williams-Baucom et al., 2010).

In the literature on couple coping and adjustment, we-talk is viewed as possessing "adaptive significance" beyond the more general finding that we-talk relative to I- or you-talk is related to marital satisfaction (Rohrbaugh, Shoham, Skoyen, Jensen, & Mehl, 2012, p. 116). This shift from being devastated and alone, to feeling fortified by the support of the spouse and the 'we' of the couple, is revealed in one man's movement from singular to plural pronoun use while recounting his early reaction to his cancer diagnosis:

> I just couldn't adjust to it. I couldn't handle it. I went outside and broke down and cried. But after I think about three, four, five days, logic began to kick in, and we said, 'Well, let's find out what the hell we got here.' We were hooked up to the Net, and within two weeks, [partner name] and I knew more about prostate cancer than the average physician. (Fergus, 2011, p. 102)

In their review of the psychological implications of we-talk in natural language, Pennebaker and colleagues (2003) report on how collective pronoun use often increases following a shared crisis and then returns to normal levels proportionate to the passage of time from the crisis. Indeed partner use of we-talk was related to better couple adjustment and reduced patient depression in a recent study of familial coping with breast cancer (Robbins et al., 2013), as well as greater adherence to a smoking cessation program for patients with smoking related health concerns (Rohrbaugh et al., 2012).

For as promising a direction as pronoun analysis is, it is important not to lose sight of the fact that we-talk is not so meaningful in and of itself; rather, it is the collective identity that it is referencing that makes the study of pronoun use valuable. More specifically, in studies of couple coping and adjustment, we-talk is assumed to signify a communal coping orientation (Rohrbaugh, Mehl, Shoham, Reilly, & Ewy, 2008; Rohrbaugh et al., 2012). Communal coping is broadly defined as adopting a team approach to addressing any stressful occurrence that is impacting upon the group – irrespective of whether one of its members is more directly affected by the stressor (Lyons, Mickelson, Sullivan, & Coyne, 1998). The responsibility for coping with the adversity is therefore not ascribed to one individual but rests with the collective. In couples, the sharing of collective resources and exchange of mutual support in this manner has been termed "dyadic coping" (Bodenmann, 2005) or "collaborative coping" (Berg et al., 2008). Embodying a we orientation in couples coping with cancer of various types and stages has consistently been associated with better adaptation in both quantitative (e.g., Badr, Carmack, Kashy, Cristofanilli, & Revenson, 2010; Berg et al.) and qualitative (e.g., Fergus, 2011; Kayser, Watson & Andrade, 2007; Skerrett, 1998) investigations. In speaking about his wife's surgical treatment for breast cancer, one man's striking use of we language offers a glimpse into his communal orientation to her disease. He remarked that, "…after the surgery, it was discovered that it was the right decision, because at the time we were thinking, well, should we have a lumpectomy or a mastectomy, and … you know … the first surgeon, like we had gone in with our list of twenty questions…"

Alongside the concrete-instrumental and emotional-affectional processes underlying conjoined coping, the development of a shared outlook vis-à-vis the problem is also instrumental to couple resilience. Open communication related to the stressful situation not only fosters transparency and trust within the relationship system (Walsh, 2003), it also tacitly objectifies the problem. This objectifying function is crucial to tapping the couple's collective resources because it presumes a shared consciousness that is enacting this objectification (Fergus & Reid, 2001). The we is therefore *indirectly* reinforced by making the problem external (White & Epston 1990), and this externalization occurs through the couple's ongoing dialogue in relation to the stressor, as well as through the coordination of their coping efforts. Like mint that is planted in a clay pot rather than the garden, when the problem is situated 'outside' of the couple, it is less likely to infiltrate and overtake them; as a result, the relationship remains defined by the greater 'us' rather than the adversarial

'it' or stressor. I suggest that this objectification process is one mechanism by which resilient reintegration occurs in couples, and specifically accounts for the fortification of the couple's experience of we-ness reflected in the common declaration by partners that, in meeting adversity, "It made us stronger."

Despite its promise, linguistic analysis is inherently limited by its reductionistic exclusion of the contextual, non-verbal, and paralinguistic features of couple communication. In other words, the study of pronoun usage fails to account for the fundamental discursive dialectic between the 'said' and the 'unsaid' (Baxter & Montgomery, 2000). This shortcoming is particularly problematic in the study of intimate partners where their communication and intersubjective meaning are based so heavily on para-verbal and non-verbal cues (Hollingshead, 1998). It is with this recognition in mind that Reid and colleagues stress that we-oriented pronouns are an epiphenomenon within the couple's ever-emergent system *secondary* to partners' *primary* experience of a mutual identification with one another and the relationship (Reid et al., 2006). Accordingly, they developed a more contextually inclusive approach to measuring we-ness that entails coding audio-recordings of couple interactions according to six "macrolevels" of we-ness. This dimensional coding scheme ranges from Level 1 in which there is a domination of "I versus you" in recounted relationship episodes, to Level 6 in which there is a mutual reflexive awareness of the relationship and an appreciation for the other's views, feelings etc. Although it includes consideration of pronouns, the coding system also accounts for intersubjective meanings and paralinguistic features of couple communication. Using this instrument, they were able to demonstrate reliably how marital satisfaction increases along with increases in relationship identity brought about through clinical intervention (Reid et al., 2006).

Co-constructed Narrative and the Reestablishment of Coherence

Couples' day-to-day conversations, and the experiences they reference, provide the material for relationship narratives. Just as personal narratives are integral to one's experience of selfhood chronicling one's values, beliefs, habits and the like (Singer & Salovey, 1993), the overlapping story of the couple is essential to the identity of the relationship and the 'we.' These are held within the relationship collective at micro and macro levels, as small story 'parts' of the larger we-story 'whole.' Regardless of whether such stories ever reach the light of day, they reside deep within the subjective world of each partner at an implicit level. Such storying and stories integrate past, present and an anticipated future into a unified whole (McAdams, 1985). In this way, shared narratives contribute to the organization and unification of the couple's intersubjective world, in a manner similar to how personal narratives serve the individual (Widdershoven, 1994). Moreover, because

shared narratives are temporally arranged, they provide a sense of continuity for those who carry them (Maines & Bridger, 1992), as well as a sense of enjoyment, and even celebration, in their telling and retelling. The mutual savoring of such 'our' stories is deftly captured in Carol Shield's (1993) novel, *Happenstance*:

> When they tell these stories to friends (as they sometimes do) Brenda never says to Jack, 'Please don't tell that old story again,' and he never says to her, 'We've all heard that one.' They love their stories and tacitly think of them as their private hoard, their private stock, exquisitely flavored by the retelling. The timing and phrasing have reached a state of near perfection; it's taken them years to get them right. It seems to Brenda that all couples of longstanding must have such a stock of stories to draw upon. (p. 142)

Shared stories are not only a testament to the life of the couple; they also define the couple and the relationship they share. As social acts, relationships are shaped through couples' stories just as societies are established and maintained through collective narratives (Maines & Bridger, 1992). This emphasis on storying as a creative, relationship building and defining process offers insight into Reik's (1944) provocative assertion that, "There is no such thing as a love story. Love is a story within a story" (p. 40). Love is not a romanticized ideal. First and foremost, love transpires through a narrativizing process that may then be fashioned into a story – or not. Perhaps, just as important as what couples *include* in their narratives is that which they choose to exclude, as Sarbin (1986) points out, "Not to spell out one's engagements means the studied avoidance of those contextual features that would render the story inconsistent, unconvincing, or absurd" (p. 16). Such "narrative smoothing" (Spence, 1986) and the related perceptual biases and selective attention processes underlie the "Glorifying the Struggle" narrative tone of satisfied couples (Carrere, Buehlman, Gottman, Coan, & Ruckstuhl, 2000). Likewise, such processes are likely enlisted in the re-establishment of continuity and coherence following biographically disruptive (Bury, 1982) life events that invariably come the couple's way.

Hermans and colleagues (1992) argue that the creation of a story necessitates interconnecting often-disparate events in meaningful ways. Thus to story is, by definition, to build coherence. If life in general is messy and fragmented, life crises are that much more so, making the need for coherence that much more pressing. A key process for fostering relational resilience is the creation of a system of belief about the adversity that is both meaningful and positive (Walsh, 2003). As Walsh states, "Although past events can't be changed, they can be recast in a new light that fosters greater comprehension and healing" (p. 409). In contrast, couples who repeatedly fail at this task, *lack* coherence. These couples – rated highly on the Chaos narrative dimension – feel distinctively out of control and unable to problem-solve around disruptive events within and impacting upon the relationship (Buehlman, Gottman, & Katz, 1992). Chaotic marriages, as compared to the "Glorifying our Struggle" marriages, are more likely to dissolve (Buehlman et al., 1992). Findings such as these support the notion that the we is contingent on successful re-integrations of past adversities, and that such re-integrations depend on an intersubjective process of co-constructed meaning-making and narrativization.

Stories about the couple's past that are vivid and emotionally charged have been construed as "relationship defining memories" (Alea, Singer, & Labunko-Messier, 2015). Such memories, when positive and well rehearsed have been associated with greater marital satisfaction (Alea & Vick, 2010). The intriguing concept of a "transactive memory" (Wegner, Erber, & Raymond, 1991) highlights another aspect of intersubjective remembering, one which functions most directly as a shared memory *system* for the encoding, storage and retrieval of relationship relevant information (Wegner, 1986) rather than as a means of establishing shared identity. Nevertheless, the transactive memory whereby each partner naturally, often unconsciously becomes the storehouse for semantic and procedural information corresponding with their respective relationship roles and "expertise," aids in the management and coordination of the couple's daily life. Moreover, the fact that partners know who-knows-what-best is a subtle expression of their intersubjectivity and a reflection of the couple's "emergent group mind" (Wegner et al., 1991, p. 923). Both transactive and relationship-defining memory processes thus assume crucial yet arguably quite distinct functions in relation to resilient adaptation for couples corresponding with functional and identity-maintenance tasks respectively.

Concluding Remarks

Based on the assumption that the couple's mutuality and shared identity are integral to couple-wellbeing, both in daily life and during times of hardship, I have sought to articulate aspects of the 'we' that are instrumental to couple resilience. This discussion was informed by dialogic dialectics as well as intersubjectivity theory, while incorporating theoretical and empirical work from social and narrative psychology, sociology, relationship science, and couple therapy. Conjoint identity processes as well as their expression were examined. These included self-other identity formation and maintenance, mutual attunement and responsiveness, co-constructed meaning and narrative, and partner languaging that references their collectivity – all of which are deeply rooted in, and expressions of, the couple's intersubjective world. In seeking to clarify these more elusive features of couple life, I have tended to isolate the relationship dyad from the broader family and socio-cultural systems in which the couple is profoundly embedded and equally as indebted to for its identity and 'self'-definition. Just as, "We [individuals] are inter-subjects. Our actions and thoughts are not reducible to us alone…" (Crossley, 1996, p. 173) So too, the couple is irreducible within its own collective social network.

The other reductive property that should be acknowledged here is the decision I made to take language and communication between partners as the window though which to examine couple intersubjectivity as it pertains to resilience. Speech acts such as collective pronoun use and the stories and memories couples share are only snapshots in time of process and content features of the couple's intricate "inter-world" (Crossley, 1996). Moreover, in emphasizing language and meaning including cognition, there has been an implied prioritization of the verbal over *both* the physical

and the less tangible aspects of couple experience. So much of the 'we' is implicit and unspoken in that it's just there. And apart from a qualifying mention of the importance of the un-*said* and the non-*verbal* aspects of verbal communication, there has been very little acknowledgement, let alone direct study, of the embodied, sensorial, and temporospatial dimensions of intersubjectivity and how these features pertain to couple adaptation (see as exceptions Fergus, 2011; van Nes, Runge, & Jonsson, 2009). By the same token, the methods discussed in this chapter are among the best currently being offered in our attempt to capture or tap into this sense of a 'we' and an 'us' – a phenomenon that is so common to couple experience on the one hand, and yet so steeped in complexity, creativity, and mystery on the other.

The final point I wish to make concerns the 'elephant in the room' of this essay – that is, couples for whom their sense of we-ness is more tenuous. What are the implications for these couples in relation to resilience? For example, self-other knowledge without mutual or altruistic intent, may be used exploitatively or manipulatively, or it may serve as a signal to a conflict one knows is about to unfold but that one simultaneously elects *not* to preempt. These are examples of intersubjectivity 'gone awry' if you will, or of intersubjective processes that are not used in the best interest of the couple or the 'we.' What about the partner who cares deeply for the other but for whom relational competence is not a strong suit? How do these couples inform our theorizing about we-ness vis-a-vis couple resilience? Moreover, who are "these couples?" Is it not more normative than otherwise to have periods where partners are more and less unified in their relationship, as the couple rides the developmental course *of* the relationship? My point here is that we-ness is not absolute and to the extent that I may have suggested so in this chapter would be an oversimplification. The literature to date suggests that the couple requires a certain degree of adversity to abrade against in order to fortify further and such resilient reintegrations beget greater resiliency. However, resilient processes and outcomes are also punctuated by moments of profound vulnerability and uncertainty in relation to the stressor and sometimes in relation to the other. Complexities such as these await further elucidation as we move forward in our study of the interaction between we-ness and resilience in couples.

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Part II
Resilient Processes and Applications to Specific Populations

Chapter 3
Resilience in Lesbian and Gay Couples

Arlene Istar Lev

There has been increased academic, political, and clinical interest in lesbian, gay, bisexual, transgender and queer (LGBTQ) people in past few decades, producing greater visibility and amplified media attention to the issues impacting the lives of sexual and gender minorities. This has resulted in a general trend towards progressive changes in public policy, culminating in greater numbers of out gay and lesbian couples forming permanent and legal partnerships, increased service provision for LGBTQ youth, and broader application of civil rights, like housing and employment protections for transgender people. Despite this generally improved social and political climate for LGBTQ people, there is a surprising dearth of in-depth research specifically focused on how same-sex couples create and sustain long-term relationships (Hunter, 2012). Oddly enough, research on gay and lesbian couples has lagged behind other areas of LGBTQ research for example, lesbian and gay parenting (Goldberg, 2010), and transgender identity development (Lev, 2004).

Until recent decades, LGBTQ people have lived closeted, furtive lives in oppressive, restrictive, and often dangerous social and political realities. Historically, they have experienced bias-related violence, discrimination in public policy including the inability to form legal partnerships or secure employment protections, as well as prejudice in the form of daily invalidating microaggressions. Yet, they have also been able to form and maintain healthy, functioning, stable families and create vibrant communities, suggesting the development of unique protective factors that function within these oppressive conditions.

Within the field of psychology, lesbian and gay intimacy has been viewed as "other," outside of the mainstream, external of what was considered normal and

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common. In the not so distant past, the very nature of homosexual attraction was viewed as pathological, and gender nonconforming behavior is still currently considered a diagnosable mental illness. Even though lesbian and gay people seek out therapy in higher numbers than heterosexuals (Cochran, Mays & Sullivan, 2003), research confirms that heterosexist microaggressions continue to be (re)enacted within the clinical relationship (Shelton & Delgado-Romero, 2011). Even among progressive clinicians, LGBTQ identities are considered "alternative," outside of normative family life and experiences (Walsh, 2011), and a side-bar to mainstream discussions within academia and clinical discourse.

Attempts at eliminating bias against LGBTQ people through education, academically and clinically, often lead to inclusion practices that are "added-on", i.e., a family therapy course discusses same-sex couples as an addendum lecture at the end of the course, instead of infusing the material throughout the course. Green and Mitchell (2008) ask their readers to imagine authoring an article entitled "Therapy with Heterosexual Couples." The title implies that the material will not be sufficiently covered in other chapters and that the information can be adequately described in one chapter, without resorting to stereotypes about straight people. The study of LGBTQ couples and families, an emerging and complex area of research and clinical exploration, is too often relegated to a postscript, an academic footnote. The reader is encouraged to recognize this dilemma in the overview that follows.

LGBTQ identities are too often "lumped together" conflating the issues facing gay men and lesbians, and merging the concerns of bisexual people of both sexes. Complex issues of transgender, transsexual and gender nonconformity are all placed under one umbrella, a sort of "pan-queerism," that minimizes salient differences in identity and community affiliation. LGBTQ is a useful way to describe broad (and necessary) political alliances, in the same way the term "people of color" describes diverse cultural communities, crossing national borders, as well as racial and ethnic identities. These are, however, inadequate terms – academically and clinically – as a way to understand the individuals and communities of people who are conflated into these larger categories; indeed, it whitewashes the salient particulars of these identities. Even discussing lesbian *and* gay couples under one rubric does a disservice to the complex and specifically gendered differences in coupling patterns, community affiliation, and cultural identities.

In this chapter, the focus is explicitly on lesbian and gay couples (the "L" and the "G" of LGBTQ), referred to as "same-sex" couples. However, it is to be remembered that many bisexual people are in same-sex relationships, where they are often invisible *as* bisexual people; of course, the same is true for bisexuals in heterosexual partnerships, a fact rarely mentioned when writing about heterosexual couples. People who are bisexual can have unique issues when partnering in same-sex relationships, including questions of affiliation, identity management, coming out, and challenges due to the "mixed orientation" within the couple, with notable differences between men and women.

Addressing the specific concerns impacting transgender people in relationships is also outside the parameters of this article, however, it is to be remembered that transgender people can identify as heterosexual, gay/lesbian, or bisexual in identity,

and some lesbian and gay couples (like some heterosexual couples) may have a transgender member. Depending on the direction, trajectory, and goal of a gender transition, a transgender person can be in relationship that is defined as either "gay" or "straight." For example, if a man is involved with a woman they are identified as heterosexual, and if the man later transitions and begins living as a woman the couple would then be identified as lesbian; neither of those terms may best describe how the couple views their own relationship. Transgender people are members of relationships that are labeled both "same-sex" and "opposite sex," and within a post-modern world of "sex changes" and "queer identities," the term sexual orientation becomes an inadequate term to fully describe coupling patterns, identities, and shifts in physical sex and gender expression (Lev & Sennott, 2012; Malpas, 2006).

The term *same-sex* will be used to describe lesbian and gay coupling, not the phrase "same-gender"; this is done consciously and purposefully. Sex describes human anatomy (as male and female); gender describes roles, mannerisms, societal expectations, clothing choices, and how people express their gender (as men and women). Some lesbian and gay people (like some heterosexuals) exhibit cross-gender expression, therefore not all same-sex relationships are actually same gender relationships (Lev, 2004). For example, some lesbian couples identify as being in butch/femme relationships, where one partner expresses a more masculine gender, although both identify as female. Although technically these are same-sex couplings, there are complex gendered patterns that may be important to acknowledge and explore that have been largely ignored in the literature (Laird, 1999; Lev, 2008).

The fields of LGBTQ studies and the specific focus on LGBTQ couple and family development is newly emerging and not yet incorporated into larger areas of psychology and marriage and family therapy. Although the knowledge base remains sparse and insufficient, nascent emerging research reveals that despite the impact of severe social oppression and ostracism directed towards sexual minorities, same-sex couples create and sustain loving relationships within strong communities that can withstand personal hardships and invalidating social and political environments.

"We-ness" in a Sea of Other-ness

Resilience research has historically focused on individuals, particularly individual children, living in unusual, high-stress, chaotic conditions. Walsh (1996) has encouraged a radically new way to view resilience, by "… shifting focus from individual traits to interactional processes that must be understood in ecological and developmental context" (p. 261). Resilience research interrogates the questions of why some people are emotionally incapacitated by persistent stress, and repeated micro-aggressions whereas others appear to emerge stronger, with increased resources (Unger, 2011; Walsh, 2011). The focus has broadened from only studying children to examining adults, and from adults to couples and families; additionally resilience research currently looks at normative development in daily life, not only unusual stress-inducing situations. Walsh suggests that familial and intimate relationships

can serve to provide "psychosocial inoculation" and actually fortify resilience (Walsh, 1996, p. 261). Relational resilience is not simply one's capacity to withstand adversity, but requires the skills to utilize, adapt, and integrate the tools and resources available, and to do so within an interdependent network that supports and sustains the process (Unger, 2011).

This idea of *relational resilience*, resilience that speaks to the "we-ness" of couples and focuses on their strengths and the process of how people mature and develop as both individuals and within couples in the face of adversity, is the bedrock of fully understanding the bonds created within LGBTQ families. Although therapy practice that is affirming to sexual minorities has developed within a strengths and empowerment prospective (see Bieschke, Perez & DeBord, 2007), the research on resilience has only recently being applied to LGBTQ couple and family building (Bigner & Wetchler, 2012). The social science study of queer folk has often focused on individuals and their identity, ignoring the role of intimacy and community which can serve as protective factors (Giammattei & Green, 2012).

Walsh (1996, 2011) has critically examined the very concept of family normalcy and shown how families that differ from the norm tend to be viewed as flawed and defective (and perhaps view themselves that way too). The myth that there is an ideal family is steeped in assumptions that are racially and culturally biased as well as heterosexist (Ashton, 2011). Atypical family structures are often labeled dysfunctional despite a growing body of research showing that "family processes matter more than family form for healthy individual and family functioning" (Walsh, 1996, p. 266). Processes that are actually typical and protective *within* alternative family structures are often judged as deficient when measured against values that are assumed to be universally normative. Harvey (2012) refers to the "hidden resilience" of LGBTQ youth, who exhibit behaviors that appear to be socially problematic, but actually serve as protective factors. For example, flamboyance, extreme gender rigidity, or desires to pass can be ways to cope with marginalized identities and struggles to develop a solid self-esteem in a condemning world. Opportunities to understand the specific resiliencies of lesbian and gay couples are too often lost because of the biased perspective of the observer who is outside of, and misinformed about, queer cultural contexts.

In many ways lesbian and gay couples are similar to heterosexual couples (Kurdek, 1993), but there are also complex differences and specific strengths born of their unique cultural context. Green says, "Heterosexuality and homosexuality are *not* logical opposites. Counterposing one against the other inevitably exaggerates their differences and minimizes their commonalities" (2012, p. 181). Lesbian and gay couples face additional stressors that heterosexual couples do not have to face, and one of those stressors is the constant comparison to heterosexual couples and values that are assumptively heteronormative.

Heteronormativity is an ideology (often unconscious) that presumes heterosexuality and promotes gender conventionality and views those values as superior to alternative forms of sexual orientation, gender expression, and family formation (Giammattei & Green, 2012; Lev, 2010). The process of de-centering heteronormativity and honoring alternative ways of creating family is at the root of how lesbian

and gay couples, as well as other sexual minorities, develop resilience and build stable families. Lesbians and gays may be functionally and structurally similar to opposite-sex couples, yet same-sex couples must make meaningful sense of the adversity they face, as cultural beings who can balance multiple interactive concerns including the environmental context of various LGBTQ communities, and their own ethnic, racial, and familial cultures.

The Alchemy of Adversity

LGBTQ identities have been formed within hostile environments, and building relational permanency requires negotiating complex social dynamics of coming out, dating, coupling, and immersion into queer cultural milieus as well as managing "degree of out-ness" with family of origin, cultural communities, and work environments (Ashton, 2011). The development of a stable same-sex "we" infers a long term developmental process from adolescence through maturity in which a positive gay or lesbian individual identity is forged in the face of societal condemnation.

Lesbian and gay people move through the same stages of the developmental lifecycle as heterosexual people but experience numerous challenges and complications unique to their minority status (Ashton, 2011). Managing social stigma and discrimination caused by homophobia is one of the most significant challenges for LGBTQ people. This means they have to cope not only with external oppression but the complex ways that minority groups internalize and come to believe the negative messages about themselves (Green & Mitchell, 2008). Living in a homophobic culture where heterosexuality is assumed and rarely questioned, same-sex couples have had to negotiate the challenges of their own coming out processes in order to forge an intimate committed relationship with one another. To come "out" presumes that one is first of all "in" something, and what LGBTQ people are in is the assumption that they are straight; heterosexuality is the socially presumed default. Being out, even if in the most minimal ways, is necessary in order to find sexual or romantic partners.

Coming out does not simply mean recognizing one's own sexual desires and preferences, but also includes coming out to others and finding and sustaining affiliations that nurture what is often a despised social identity. Coming out is a process complicated by one's social position regarding age, race, ethnic and religious heritage, geographic locality, access to queer communities, and the anticipated and actual reaction of family and loved ones (Green, 2011).

The psychosocial stages of coming out delineates a common sequence of processes and dynamics that LGBTQ people experience in developing an integrated identity (Ashton, 2011). For some people, this process begins as a child or teenager, and for others it does not begin until middle age or later, sometimes after people are heterosexually married. Negotiating adversity and potential rejection during the coming out process can be difficult, particularly for those who are young and dependent on families that are not supportive, as well as those whose cultural or religious communities view homosexuality as a moral failure (Harvey, 2012; LaSala, 2010).

Young people coming out in childhood and adolescence are immersed in the values and belief structure of their parents or caregivers; they are dependent on them for not only food and shelter, but emotional nurturance. Unlike other minority groups, LGBTQ people are seldom reared in families who experience the same minority identity, therefore parents may be uneducated and poorly prepared to assist their children in healthy identity development. Research suggests that it is common for parents to initially be rejecting towards their LGBTQ children (D'Augelli, Hershberger, & Pilkington, 1998; Harvey, 2012; LaSala, 2010, Ryan et al., 2009, 2010). This leaves many LGBTQ youth without parental assistance to navigate their emerging sexual and gender identities and early explorations into the LGBTQ communities.

Ryan and her colleagues at the Family Acceptance Project have found that rejecting behaviors from family were associated with significantly poorer psychosocial outcomes, including higher rates of depression, increased substance use, and unprotected sexual activities (Ryan, Huebner, Diaz, & Sanchez, 2009, 2010). This is supported by decades of research revealing high incidences of suicidal ideation, school drop-out rates, homelessness, drug and alcohol abuse, and victimization for LGBTQ youth (D'Augelli, Grossman, & Starks, 2006; Harvey, 2012; LaSala, 2010; Nuttbrock et al., 2010).

LGBTQ people experience daily microaggressions due to their sexual orientation and/or gender expression including institutionalized discrimination, vilification of their sexual desires, denial of their chosen familial bonds, and endless derogatory marginalization in social discourse and media portrayal (Meyer, 2003; Nadal et al., 2011; Sue, 2010). This is reflected in elevated signs of mental health problems in adulthood, including increased depression, anxiety, substance abuse and other stress-related disorders (Cochran et al., 2003; Hatzenbuehler et al., 2010; Meyer, 2003; Nuttbrock et al., 2010) due to invalidating social environments. It is clear that the psychological consequences of coming out are potentially detrimental, influencing self-esteem as LGBTQ people internalize these messages of social condemnation and rejection; this is especially true for those who are young, vulnerable, and marginalized (Harvey, 2012).

The qualities of attachment and parental nurturance in childhood are known to be important for psychological health, but it might also influence how young people experience coming out. Research has shown that difficulties in childhood attachment may negatively impact coming out processes and lifelong self-acceptance. Mohr and Fassinger's research (2003) describe how low levels of parental support were associated with higher anxiety, and that people with difficulties accepting their own sexual orientation were more likely to exhibit a pattern of attachment anxiety and avoidance behaviors. In turn, patterns of avoidance were associated with lower levels of self-disclosure in daily life and individuals who are more out typically report less stress and fewer symptoms of depression or anxiety (Vaughan & Waehler, 2010).

It is undeniable that discrimination, bias, and microaggressions directed towards one's identity can be debilitating (Meyer, 2003; Nadal et al., 2011; Sue, 2010). There is also, however, evidence that developing skills to manage the stress of being a sexual minority might also be facilitative and can enhance coping strategies. It has

been suggested that unique strengths are developed by successfully adapting to the significant adversity inherent in coming out as lesbian or gay. Strength related growth, or coming out growth, describes how negotiating the processes of coming out and managing oppressive circumstances can transform the experience of minority stress into opportunities for enhanced growth and assist in the development of stable identities (Bonet, Wells, & Parsons, 2007; Vaughan & Waehler, 2010). Coming out to others can positively influence how people perceive and experience themselves as gay or lesbian people, and also improves their perception of, and relationships with, other gay-identified people (Vaughan & Waehler, 2010). Some of the benefits of coming out growth include: increased honesty and authenticity, lower use of drugs and alcohol, higher levels of social support and community integration, lower levels of depression, anxiety, stress and other mental health challenges, increased levels of self-disclosure and self-acceptance, and better skills at coping with oppression and negative societal hostility (Bonet et al., 2007; Vaughan & Waehler, 2010).

Although research has shown that families of origin are often initially rejecting, it also confirms that family relationships shift and grow as adolescents and their families discover and accept an emerging gay and lesbian identity (LaSala, 2010). Families have their own coming out process that must be negotiated and as they struggle with shame, guilt, and confusion, they must also make meaning of the same negative social messages about homosexuality with which their children have contended. This process can bring families together and serve as bridge for increased communication and a strengthening of family bonds. Ryan and her colleagues (2009, 2010) have demonstrated that lessening familial rejecting behaviors and increasing family acceptance will significantly improve outcomes and increase self-esteem.

Negotiating coming out is a lifelong process, not a single act of disclosure, and LGBTQ people are repeatedly in situations where they must make choices of what to let others know about their sexuality, their identity, and their families. The resilience necessary to cope with repeated societal microaggressions emerges from nurturing relationships with families of origin as well as negotiating adversity within the confines of a heteronormative and invalidating cultural environment. Successfully coming out is a necessary preparation to finding and joining with a same-sex partner, and the competence developed by coming out to families that are often initially rejecting, as well as confronting societal bias, may contribute to increased skills at partnership building.

Same-Sex Couples: Challenges

Green (2004) suggests that there are "three interrelated risk factors for lesbian and gay couples forming a partnership: (1) homophobia (external and internal); (2) lack of a normative and legal template for same-sex couples; and (3) lower levels of family social support" (p. 290). The challenges of homophobia and lack of familial support were discussed above; the focus here is the lack of a normative legal

template. Without a relational template for same-sex couples, Green (2004) says, there is no "preordained prescription for what being a same-sex couple means" (p. 291). Same-sex couples need to negotiate what has been for heterosexuals very basic and assumed (and gendered) tasks, i.e., who pays for the date and who takes out the garbage, as well as complex psycho-emotional processes, i.e., who initiates sex, and which partner will get pregnant and carry the couple's child. Green says that the lack of a relational template creates relational ambiguity (2008, 2011).

Relational ambiguity is a concept expanded from Pauline Boss's theory of "boundary ambiguity." Boss defined boundary ambiguity as "a state in which family members are uncertain in their perception of who is in or out of the family and who is performing what roles or tasks in the family system" (Boss & Greenberg, 1987, p. 536, as quoted by Green & Mitchell, 2008, p. 667). Relational ambiguity is at the heart of any discussion about relational resilience in same-sex coupling since there has been no cultural script or set of rules for how lesbian and gay couples "should" be a couple, or present themselves to the society. Patterson and Schwartz (1994) say that couples must be able to "telegraph to others the shape and seriousness of their commitment. They must invent some 'marital' rules, borrow others, and pick some to avoid" (p. 4). In other words, it must be an active process, and one that is not just internal to the partners, but also involves ongoing communication with their family and social world.

Same-sex couples have had to create healthy boundaries around the relationship, in the absence of culturally proscribed ones. Historically there have been legal constraints on establishing protective boundaries around the relationship, leaving the relationship less secure financially, legally, and emotionally. Lesbian and gay couples have long desired to secure their relationships, although this has only recently become possible with changes in law and policy which have increasingly made same-sex marriage possible in many countries and U.S. states. Hatzenbuehler and colleagues (2010) examined how the lack of institutional recognition can influence mental health for LGB people, and they found that LGB individuals living in states with constitutional amendments banning gay marriage experienced increased rates of psychiatric disorders. Research shows that couples who had civil unions have more financial and familial intertwinement of their lives, and lesbian couples were less closeted about their sexual orientation (Solomon, Rothblum, & Balsam, 2004). The cost of relational ambiguity is high and increased civil rights clearly serves as a protective factor.

In order to resolve relationship ambiguity, same-sex couples have historically had to engage in a complex dialogue about their commitment, as well as manage issues of power and roles. What is accomplished easily with a marriage certificate for heterosexual couples must be established through wills, powers of attorney, health care proxies, etc., at great expense and with necessary forethought for the gay and lesbian couple before marriage equality laws. The communication necessary to negotiate partnerships can be a great boon to the relationship, when this process is successful. However, when it is not successful, the lack of legal bonds can be devastating. This is, of course, rapidly changing as lesbian and gay couples are now legally allowed to marry in many states.

Relationship ambiguity is poignantly illustrated by Allen's (2007) personal narrative of having her lesbian partner end their relationship, refusing to allow her contact with a child she had parented since birth and raising the question of how one can divorce when there is no recognition of marriage. When her and her partner broke up, her partner took their son; she had no legal standing as a non-biological parent, creating a painful, relentless sense of loss, with no hope of legal or political redress, creating what she referred to as the "structural ambiguity of being a politically and legally invisible family" (p. 181). In a heterosexual relationship, her rights as a parent would have been protected, regardless of her ex-partner's desires. The cognitive dissonance of both being a family and yet not having the power to protect those you love or determine the direction of your future together speaks to the ambiguity of relationship status within same-sex coupling and its impact on family-building.

Without legally protective and socially affirmed rituals, when does a relationship move from dating to something more serious, and when does a relationship in trouble cease to be a relationship? When boundaries are permeable, how are they negotiated? Heterosexual relationships are governed by a set of social and legally sanctioned rituals from buying engagement rings, to owning a house and putting both spouses' names on the deed, to complex laws dividing property when there is a divorce. Surely not all heterosexual couples follow these patterns, and some vocally rebel against them, but until relatively recently same-sex couples who wanted to embrace these rituals were blocked by laws that have not recognize their union as legitimate, and by the potential social discomfort caused when they shop for an engagement ring, or new house, within a heteronormative and often blatantly homophobic culture. Additionally, family members, as well as shopkeepers may or may not honor these attempts at creating security in their relationship, and might even resort to minimizing or mocking responses. The couple, as individuals as well as a unit, must confront societal homophobia as well as their internalized fear of rejection or exposure. Indeed, due to ambiguity of rules, it may not be easy to decide *who* buys an engagement ring *for whom* in relationships where gender roles have not been firmly established and rigidly adhered to by socialized male/female constraints! Clearly, relational ambiguity can be a potential minefield of stress and adversity, yet the creative solutions to address this ambiguity are one of great strengths of same-sex relationships. Undoubtedly, the excitement over marriage equality and the Supreme Court decision that the Defense of Marriage Act (DOMA) is unconstitutional, fosters a more supportive social environment for same-sex couples and resolves some relationship ambiguity enabling them to feel more secure, psychologically as well as legally.

Same-Sex Couples: Strengths

Relational or couple resilience infers that a couple is successfully coping with adversity and research shows that lesbian and gay couples are remarkably similar to heterosexual couples in terms of how they manage their daily lives and address

conflicts within their relationships (Kurdek, 1993). Same-sex couples organize their lives in similar ways as heterosexual couples in the sense that they date, move towards greater intimacy, and begin a process of pair-bonding (Ashton, 2011). They celebrate milestone events like anniversaries, they move in together, set up housekeeping, and plan on having children (Bigner & Wetchler, 2012; Goldberg & Allen, 2012). Like all other couples they manage stressful events like illness or infidelity, and eventually they face aging issues together (Dziengel, 2011; Genke, 2004; Witten & Eyler, 2012).

Quam and colleagues (2010) found that a majority of older same-sex couples lived together and/or owned a home together, and had shared bank accounts and credit cards. Research shows that financial interdependence, commitment rituals, and securing legal ties to one another in the absence of marital contracts was part of lesbian and gay coupling for decades, long before the explosion of media attention and increased social acceptance (Bryant & Demian, 1994).

Lesbian and gay couples describe a high level of relationship quality, satisfaction and stability (Bryant & Demian, 1994; Connolly, 2005; Gottman et al., 2003; Green & Mitchell, 2008; Hunter, 2012; Kurdek, 2005). They tend to resolve conflict constructively, have high rates of communication, and place great value on intimacy and closeness. Jonathan (2009) studied communication patterns in same-sex couples and identified that lesbian and gay couples showed a high attunement to one another's needs, referred to as an attuned-equality pattern. Same-sex couples were attentive to fairness and justice, engaged in conscious relationship strategies, including shared decision-making, and careful conflict management. There was an ongoing evaluation of the relationship and a willingness to re-negotiate when conflict arises. Additionally, male same-sex couples reported increased autonomy, and female same-sex couples reported high intimacy and equality (Gottman et al., 2003).

In most heterosexual relationships gender plays an important role in determining both daily tasks, and psycho-emotional relational rules regarding communication patterns and childrearing practices; indeed gendered expectations permeate every area of marital life. Gender is also a salient factor for same-sex couples, but since gender dynamics are not based in heterosexual (and heterosexist) rules (Hunter, 2012) the role of gender has often been under-explored and perhaps sometimes completely misunderstood.

In gay and lesbian partnerships gender is a relational task that is negotiated depending on numerous variables, including personality and interests, sub-cultural community patterns and values, and may be re-negotiated depending on the shifting needs of the individuals and family through the course of the lifecycle (Connolly, 2005; Green & Mitchell, 2008; Jonathan, 2009). Since neither partner enters the relationship with an expectation that their social roles will be based along gender lines, both men and women are "allowed" to explore both traditionally masculine and feminine roles. No one is designated as "the person who takes out the garbage," or "the one who will get pregnant," these relational tasks must be discussed and negotiated, reflecting a high need for communication and conflict resolution.

Contemporary research has consistently shown that same-sex couples exhibit a value of equality and shared power in how they organize their daily lives. Lesbian

and gay couples are active participants in co-creating their relationship. There is an interactional pattern of closeness, a strong desire to create an equality of power, and openness of communication (Green, 2011); this is especially true in lesbian relationships (Connolly, 2005). Connolly (2006) refers to a dynamic of mutuality, a strong "personal dedication to the relationship" (p. 151). Couples often develop an "us-against-the-world" perspective (Connolly , 2006, p. 151), which can assist in couple cohesion, the sense of being a "united front" (ibid) against oppression and discrimination.

Decision-making regarding household labor becomes a mutual task, and in the majority of same-sex couples the household responsibilities are divided relatively equally between the partners (Jonathan, 2009; Kurdek, 2005; Quam et al., 2010; Solomon, Rothblum, & Balsam,, 2004). In families with children, child-rearing chores and parental responsibilities are also equally shared in lesbian and gay couples (Goldberg, 2010, 2012). Interestingly, it is also true in lesbian relationships where gender roles are explicitly butch/femme identified; Levitt, Gerrish and Hiestand (2003) discovered that although gender was a salient factor in how these couples identified and expressed themselves, housekeeping duties were *not* divided along traditional gender lines. As Lev (2008) has said,

> Examining domestic chores and parenting styles, or even power dynamics and communication styles, may not accurately measure the way that gender operates within same-sex couples, and for butch/femme couples it may actually mask the way that gender roles are understood and interpreted within the relationship. If research about gender roles assumes a power differential attached to the gender expression, the "equality" within the lesbian couple may hide important aspects of how gender functions in the relationship that is neither traditional (i.e., based in hetero-normativity) nor hierarchal. (p. 138)

Within heterosexual coupling, gender role expectations have symbolized complex power dynamics between the members of the couple. Examining gender in same-sex couples may require a different lens, a less heterosexist lens, to determine the meaning of behavior. Gay and lesbian couples are able to explore gender, "play" with gender, express gender, without it necessarily being attached to traditional gender roles, or societal rules. The stay-at-home mom may be a dad who lifts weights and bakes cookies. It is not that gender is absent in gay and lesbian couples; it may simply reflect different cultural patterns. It is necessary to deconstruct the meaning of gender and roles, without heterosexist assumptions. For example, the closeness in lesbian relationships has often been mislabeled as "fusion," instead of seeing the deeper intimacy between two women as a potential strength of their female coupling (Green, 2011; Macdonald, 1998; Spitalnick & McNair, 2005).

Research on sexuality is particularly susceptible to a heterosexist analysis. Many studies have shown that lesbians tend to have less frequent genital sex when compared to heterosexual or gay male couples. This is often stated as a "problem," ignoring the equally compelling information that lesbians express higher satisfaction in their intimate sexual relationships (Green, 2011; McDonald, 1998). If researchers perceive that sexual frequency trumps sexual satisfaction, then lesbians are seen as having a deficit in their sex lives. In a similar vein, research has also shown that non-monogamy and open relationships are more common in gay male relationships

(Bryant & Demian, 1994; LaSala, 2004; Spitalnick & McNair, 2005). Within the context of a heterosexual lens, a lack of fidelity would likely be viewed as a lack of commitment, but research does not show that gay male couples are less committed or happy in their relationships. When examining coupling patterns and gender, same-sex couples should not be judged within the same value orientation as heterosexual couples, but rather with a queer cultural lens. Negotiating complex areas of gender and sexuality actually requires high levels of communication and sophisticated skills of conflict resolution, which may indeed be a strength, a hidden resilience, for gay and lesbian couples.

It is possible that same-sex couples have an advantage to being reared in same gender role as their partners. They may be similar to one another in important ways, and this similarity may increase closeness, cohesion, egalitarianism, and emotional expressiveness, especially for women. This may lead to great attunement during conflict since they approach disagreements from a position of peer equality and humor (Gottman et al., 2003) which may assist the couple in re-bounding from adversity with great ease (Connolly, 2005, 2006).

Strength in Numbers: LGBTQ Community

As part of the process of coming out, most gay and lesbian people recognize that they are different in important contextual ways from heterosexual peers and also similar in core ways to other LGBTQ people, so they seek out communities that will affirm and mirror their emerging identities. Seeking out community and finding resources, social services, and support has been instrumental in assisting people in developing a positive queer identity. From facing the negativities of oppression and minority stress, through the process of reframing and reinventing, LGBTQ people have created an affirming cultural community, which helps sustain long-term friendships, intimate relationships, and creates an environment for family building. Green (2011) says, "it evolved over many decades as part of a secret society that protected its members against physical, economic, legal, and social threats to survival and well-being" (p. 176).

Like all communities, the community that gay and lesbian people have built has its own cultural norms and behavior patterns. It has served as a safe harbor for queer people who have most often been raised by heterosexual parents within straight culture. Living without formal recognition for same-sex pair boding, a vibrant culture has arisen that borrows from the mainstream culture, but is willing to also stretch into new ways of building intimacy and family. LGBTQ people have built communities, with its own set of meta-rules and patterned ways of communication. It is common, for example, for LGBTQ people to remain close to ex-lovers, and build families based not on blood, but love and commitment. For those who have been ostracized from their families of origin, the LGBTQ community often replaces the family that has been rejecting or abandoning and becomes an extended family, providing nurturance, support, and a place to celebrate holidays, or seek our comfort

in trying times. There is also great variety of intimate relationship arrangements that are acceptable within the LGBTQ community, including open relationships and polyamory (Green & Mitchell, 2008; LaSala, 2004).

Research consistently shows the importance of the LGBTQ community in the lives of lesbian and gay couples (Dziengel, 2011; Genke, 2004; Green, 2011; Vaughan & Waehler, 2010). Involvement in the LGBTQ community was also found to predict high levels of coming out growth (Bonet et al., 2007; Vaughan & Waehler, 2010), because being with other queer people increases individual self-esteem and challenges isolation. Additionally, the LGBTQ community has become a powerful political voice advocating for marriage equality, and empowering queer people to demand equal treatment and fight oppressive laws.

The LGBTQ community is also a place to meet others for dating as well as finding mutual supports for socializing. This is especially true for those who live more rurally, or in more insular religious or cultural communities; the Internet has been instrumental in creating support for LGBTQ people who are more isolated (Giammattei & Green, 2012). Involvement in the LGBTQ community has been essential for creating supports for people living with AIDS, as well as coping with other illness and aging issues (Dziengel, 2011; Genke, 2004; Witten & Eyler, 2012). In this sense community-building is a source of resilience, a mutual aid relationship, where those coming out seek out the community while developing their identity and their continued engagement in the community creates a lifeline for those who follow.

Same-sex couples have role models within the larger community to mirror their experiences. As the LGBTQ community has grown, multiple communities and identities for sexual minorities have expanded, and possibilities for post-modern coupling and sexual expression have also broadened. The experience of being around others who can affirm relationships that are outside of the heteronormative culture, creates a "narrative coherence" (Walsh, 1996, p. 267), that mirrors ones personal experience, helps to normalize them, and then creates an environment to make meaning of shared identities and relationships.

Relational Resilience in a Changing World

The process of de-centering heteronormativity, and developing supportive communities, has given lesbian and gay couples the ability to re-vision their relationships, and create unique family forms. The nature of same-sex coupling allows for greater diversity in how families are organized around gender, and influences greater flexibility in all areas of life from household chores to sexual intimacy. Relational resilience is born from adversity; many of the unique family forms have been forged from surviving difficult conditions.

Lesbian women and gay men forming intimate partnerships need to negotiate complex interactions within society including: discrimination and bias in the form of blatant and sometimes violent homophobia; invisibility due to ubiquitous heterosexism

and misinformation about queer identity and communities; and harsh gender role socialization and societal punishment of gender transgressions. Additionally, they must manage equally complex psychological and intrapersonal processes including struggles regarding coming out and identity self-disclosure as well as issues of relational ambiguity, forging a functioning couple identity without culturally proscribed roles or legal boundary containment.

There are also specific tasks in individual relationships that must be successfully negotiated in order to form stable, loving relationships that can withstand normative and out-of-the ordinary crises. For example, partners might come out at different ages or stages in the lifecycle, or come from different religious or cultural backgrounds, and might not be comfortable with similar levels of disclosure about their relationship. They might have to face illness or infertility or unemployment. Lesbian and gay couples must develop the protective factors necessary to confront the normative interpersonal challenges that impact all couples regardless of their sexual orientation.

In recent years, public policy has shifted and these changes have created many benefits for the LGBTQ community. For example, adoption by out lesbian and gay people has become socially sanctioned by major national child welfare organizations, and more municipalities have instituted discrimination protections in housing and employment for transgender persons. Same-sex marriage, viewed as a pipe-dream a mere decade ago, has gained traction and become a legal fait accompli in many countries and in increasing numbers of U.S. states. However, it is easy to forget while these changes are celebrated that most U.S. states still do not allow same-sex marriage, or have protections for queer families in housing or employment and most LGBTQ people still face complex adverse social situations. Bias-related violence remains an ongoing threat, even in progressive urban environments.

The tide, however, has clearly turned from the closeted, fearful homophobia common only decades ago. Green and Mitchell (2008) cite D'Augelli and colleagues (2006) research showing that young lesbian and gay teens plan to marry and have children when they are older, something an older generation of LGBTQ could not have imagined envisioning as young people. There is tremendous hope for the future of lesbian and couples, building on long history of creating relationships in hostile and negative environments.

Research continues to show that same-sex couples value communication, and develop a strong sense of "we-ness" and mutuality, which are protective factors against both external oppression, and relational ambiguity. As LGBTQ people increasingly secure legal rights and become integrated in positive ways into mainstream culture, the challenge is to maintain the unique relational resiliencies developed within queer communities and retain the lessons learned while living as outlaws.

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Chapter 4
Sexual Resilience in Couples

Andrea M. Beck and John W. Robinson

Joan looks at her husband and sighs to herself. "Why can't it be like it was?" she thinks. "It used to be close and intimate when we made love. We used to have such a good sex life. Since his surgery, it all seems so unnatural, sometimes even forced. I feel sad; sometimes I feel it might be easier to just forget it."

Rick looks down, avoiding his wife's gaze. He too longs for how sex was before he had his prostate cancer. "Why is it all so complicated and why can't we go back to the way things were?" he wonders. "She hardly seems interested in touching me anymore, and even if she did, it would probably turn out badly. It's so frustrating, and sometimes it feels easier to just forget it. Perhaps, we should try a vacuum erection device. That might help me get a better erection."

Why is it that some couples are resilient and weather a storm in their sexual relationship, coming through it with their sexual relationship intact, while others find their relationship stuck? This is the question we address in this chapter on couples' sexual resilience.

Sexual Resilience in Couples

Couples go through many stages and seasons in their relationships, whether the relationship is short- or long-term. Many events and experiences in a couple's life can affect their sexual relationship. Some couples are able to weather these storms and maintain or restore a satisfying sexual relationship, while other couples find the difficulty insurmountable and feel sexually dissatisfied, often grieving the loss of their past sexual relationship for many years.

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Psychologists have long recognized the abilities of humans to adapt to and overcome adversity. Individuals, families and communities are able to rebuild their lives even after devastating tragedies. Resilience is the ability to withstand stress, regain strength, adapt, and find solutions to life's challenges and setbacks. Being resilient does not mean going through life without experiencing stress and pain. All people face challenges, and all people feel grief, sadness, and a range of other emotions after adversity and loss. Resilience refers to the capacity to work through the emotions and effects of stress and painful events.

A specific type of resilience, manifested in couples as well as individuals, is sexual resilience. Sexual resilience, as we have come to understand and define it, is a term used to describe individuals or couples who are able to withstand, adapt, and find solutions to events and experiences that challenge their sexual relationship. Although any experience that places stress on a couple can have unexpected effects on the sexual relationship, the most common challenges to sexuality include the birth of the first child, where the demands of parenting often eclipse the sexual relationship between partners; the onset of a physical or mental illness, such as cancer, diabetes or depression; an emotional blow to the relationship, such as betrayal or hurt; lack of relational intimacy, such as becoming absorbed by other priorities such as career; and changes associated with aging, such as vaginal dryness or erectile dysfunction.

Sexual resilience is a term that we use to describe couples who are able to adapt to challenges to their sexual relationship in ways that maintain or restore a satisfying sexual relationship. These couples are able to assess their current sexual relationship, find and implement potential solutions, and adapt to the challenges at hand. Sexually resilient couples are those who have faced significant challenges and were able to come out on the other side equally or more satisfied with their sexual relationship.

Although challenges to couples' sexual relationships are ubiquitous, few resources exist to guide couples through the process of working through these difficulties. Even when accessing services from a professional with specialized training in sexuality, whether a physician, counselor, or psychologist, few theoretical frameworks exist to guide the professional in carrying out their work. There is a paucity of evidence-based models of sexuality that provide a unifying theory upon which to base one's work with couples on matters of sexuality. What does exist in the literature are suggestions for addressing sexual problems. Missing, however, is a comprehensive theory that is able to provide insight into couples' sexual resilience.

Existing Models of Couple Sexual Functioning and Intimacy

The Good-Enough Sex Model

Until recently, the most comprehensive model of sexuality has been the "Good-Enough Sex" model of Metz and McCarthy (2007). Although the authors present several guiding principles of healthy sexuality, the most fundamental postulate is that couples need to have realistic expectations of their sexual encounters- accepting

mediocre, dissatisfying, or dysfunctional sexual experiences as "good-enough sex," rather than expecting that every sexual experience will be highly satisfying. Adopting realistic expectations helps couples to avoid negative feedback loops, whereby one dissatisfying sexual experience causes distress that creates a negative expectation for all future sexual encounters.

Most of the work carried out by Metz and McCarthy focuses on the concept of sexual desire, or the dysfunction that occurs when one or both partners experience inhibited sexual desire (McCarthy, Ginsberg, & Fucito, 2006). In fact, the authors argue that desire and satisfaction are the key factors in maintaining a healthy sexuality. They even provide a prescription for increasing desire that entails integrating intimacy, non-demand pleasuring, and erotic scenarios with positive, realistic sexual expectations. Sexual resilience is achieved by not avoiding sex or feeling self-conscious, and by maintaining a flexible sexual relationship.

Although the authors acknowledge that sexual dysfunction is generally multi-causal, the only specific cause of sexual dysfunction offered is the existence of unrealistic expectations in one or both partners. Thus the Good-Enough Sex Model does not provide a framework for understanding the development of inhibited sexual desire, sexual avoidance, self-consciousness, or a rigid sexual relationship, apart from unrealistic sexual expectations.

The Sexual Health Model

The Sexual Health Model (Robinson, Munns, Weber-Main, Lowe, & Raymond, 2011) was originally developed in the context of safe sex practices, specifically HIV prevention, but has more recently been applied to the treatment of a variety of sexual dysfunctions, including orgasmic and desire disorders. The authors' treatment program promotes and teaches ten essential components of sexual health, which include: (1) the ability to talk openly and explicitly about sex, (2) understanding the impact of one's gender and cultural heritage on sexual identity, attitudes, behaviors, and health, (3) having a basic knowledge and acceptance of one's anatomy, sexual response, and sexual functioning, (4) knowing and taking care of one's body, such as getting regular medical care, (5) addressing barriers to sexual health, such as sexual abuse and mental health issues, (6) having a healthy body-image through the acceptance of a wide standard of beauty, (7) appreciating the role of masturbation and fantasy in healthy sexuality (i.e., masturbation and fantasy are normal and healthy, rather than deviant, immoral, or unhealthy), (8) having a positive attitude toward sexuality, including the ability to be assertive about one's sexual desires, (9) addressing conflicts in the relationship that interfere with intimacy, and (10) being able to integrate and assume congruence between one's sexual behaviors and values, and one's spiritual, ethical, and moral beliefs. In terms of sexual resilience, Robinson and colleagues would argue that any event or experience that challenges a person's ability to successfully negotiate one of the ten components of sexual health could compromise that person's sexual health.

The Flexible Coping Model

Originally developed in response to a dearth of research and intervention strategies for addressing sexual concerns for those with chronic illness and those with cancer, the Flexible Coping Model (Reese, Keefe, Somers, & Abernethy, 2010) posits that the level of flexibility a person has in regard to his or her definition of sexual activity and the centrality of sexual function and activity, will directly affect how the person responds to sexual challenges. First, individuals who have rigid and narrow definitions of sexual activity, for example, that sexual activity is seen as synonymous with intercourse, may respond to an event that compromises their ability to engage in intercourse with helplessness and avoidance. In this case, treatment would focus on helping the individual to expand his or her definition of sexual activity, as well as to engage in a wider variety of sexual activities. Conversely, a person whose definition of sexual activity includes intercourse, non-intercourse sexual activities, and non-sexual intimacy, is more likely to appraise sexual challenges as manageable and to cope more successfully. A person who relies heavily on the importance of sexual functioning within their self-concept will likely struggle more than a person who views sexual functioning as less central. Treatment strategies, then, would focus on helping the individual set more realistic and attainable goals.

The Sexual Self-Schema Model

Anderson and colleagues proposed the model of sexual self-schemas (Andersen, Cyranowski, & Espindle, 1999). Sexual self-schemas are argued to be generalizations about the sexual self that guide sexual behavior and influence the processing of sexual information. Sexual self-schema is typically measured using the Sexual Self-Schema Scales, which contain a series of trait adjectives (such as "cautious" or "loving") and result in the categorization of individuals into one of three main dimensions. For women, the dimensions include passionate/romantic, open/direct, and embarrassed/conservative (Andersen, 1999; Carpenter, Andersen, Fowler, & Maxwell, 2009). To determine a total score, items from the first two factors are summed and items from the third factor are subtracted. For men, the Sexual Self-Schema Scale is made up of three similar, but not identical, dimensions including passionate/loving, powerful/independent, open/liberal, and the total score is determined by summing all three factors (Andersen, 1999; Andersen et al., 1999). On both, low scores represent a negative sexual self schema while high scores represent a positive sexual self schema.

Although the sexual self schema model posits that a positive self schema is a protective characteristic that provides a person with resiliency in the face of sexual dysfunction, the Sexual Self-Schema model itself has a broader range (Andersen, 1985, 1994, 1999). This model predicts that those individuals who have a positive sexual self-schema will adjust to sexual dysfunction better than those who have a negative self schema (Andersen, 1999; Carpenter et al., 2009). Interestingly, the authors also hypothesize that negative sexual self schema may be related to lower levels of passionate love and anxious or avoidant romantic attachments.

To date, the studies that have been carried out to test the sexual self schema model have been correlational in nature (Carpenter et al., 2009). There is limited empirical support that a positive self-schema predicts better sexual adjustment, and the interactions between partners are not taken into account.

The Physical Pleasure: Relational Intimacy Model of Sexual Motivation (PRISM)

The models presented thus far are effective in articulating many components of healthy sexuality, such as having a sex-positive perspective, realistic expectations, and flexible attitudes toward sex. However, in our clinical work with couples experiencing sexual dysfunction after treatment for prostate cancer (PrCa), we found that these models did not fully explain why some couples are able to adjust and continue to enjoy sex while others are not and thus stop having sex altogether. After treatment for prostate cancer for example, most men experience some loss of erectile function that makes penetrative sex difficult, if not impossible, without the use of pro-erectile aids (i.e., intracaversonal injections, vacuum erection devices or oral medications like Viagra, Levitra, Cialis and Staxyn). We and others have found that even if couples find an erectile aid that gives a man an erection sufficient for penetration, half of these couples stop having sex within a year (Matthew et al., 2005; Schover et al., 2002).

The PRISM Study of Sexual Resilience

To better understand what distinguishes couples who adapt successfully (i.e., resilient couples) from those who do not, we conducted in-depth interviews with both successful and unsuccessful couples. Ten heterosexual couples who successfully maintained satisfying sexual intimacy and seven couples who had not maintained satisfying sexual intimacy after prostate cancer treatment were interviewed for the study and analyzed using a qualitative coding procedures. The result is the Physical Pleasure – Relational Intimacy Model of Sexual Motivation (PRISM; Beck, Robinson, & Carlson, 2013).

Methods

After recruitment and informed consent, couples were interviewed in-person with their partner. A few day later, each partner was interviewed individually. In total, 51 interviews with 17 couples made up the data set. To enhance participants' recall of events and experiences, interviews followed a chronological format, whereby specific time points were used as benchmarks to cue participants' memories (Geiselman, Fisher, MacKinnon, & Hollan, 1986). Specifically, participants were

asked to describe their sexual relationship before the diagnosis of prostate cancer, after diagnosis but before treatment, during the time soon after treatment, and currently. The strategies that the couples used to maintain sexual intimacy were specifically queried. As each interview was reviewed, the researcher took note of new themes to inquire about in subsequent interviews. The interviews were audio-recorded and subsequently transcribed verbatim.

Interviews were analyzed according to the qualitative procedure of grounded theory, as outlined by Strauss and Corbin (1998), allowing the theory to emerge rather than forcing a theory based on preconceptions. The constant comparative method was used whereby the researcher allowed the theory to emerge by generating themes based in the data and delineating their relationships by comparing categories systematically. The grounded theory analysis resulted in the generation of one foundational theme and three important secondary themes. To identify the foundational and secondary themes, all interviews were first coded line-by-line, and a comprehensive list of themes was generated. These initial themes were then organized into hierarchies, in which specific categories were subsumed under more general categories. This helped to clarify the relationships between the themes, as well as winnow out the themes that were only distally or not at all related to the research question.

The researcher then asked specific questions of the data in order to highlight those themes that most directly addressed the research question, "How are some couples able to maintain satisfying sexual intimacy after prostate cancer, while others are not?" First, the researcher asked, "What are the characteristics or qualities associated with satisfied couples? How would I describe satisfied couples?" From this question, the three secondary themes of *acceptance*, *flexibility*, and *persistence* were chosen as most reflective of those couples who were able to maintain sexual intimacy after prostate cancer.

In order to explain why some couples were able to have the characteristics of acceptance, flexibility, and persistence, while other were not, the researcher asked, "What is the difference between couples who were accepting, flexible, and persistent, and those who were not?" Based on this question, the theme of *value placed on sex* was chosen as the foundational notion best explaining the fundamental difference between those couples who were satisfied with their sexual intimacy and those who were not.

Study Findings

The main finding, which also forms the core of the PRISM model, is that peoples' sexual values affect the way in which they respond to events that challenge their sexual functioning. From a values-based perspective, the two main – although not the only- reasons people have sex are for (1) physical pleasure and (2) relational intimacy. Valuing sex for physical pleasure means that people are motivated to engage in sexual activity because they enjoy the sensorial and physiological feelings associated with sexual activity. In this case, sex is experienced as a release, as

physically satisfying, as pleasurable, and as a source of physical gratification. People who value sex for physical pleasure engage in sex because it feels good physically.

Valuing sex for relational intimacy means that a person is motivated to engage in sexual activity because they enjoy the feeling of being emotionally close to their sexual partner. In this case, sexual intimacy is experienced as a connection with a valued other person, as intimate, and promoting a sense of well-being and romance. People who value sex for relational intimacy often described finding enjoyment out of the quality time they spend together when engaging in sexual activity and feel connected on an emotional level. These individuals seek out sexual experiences to connect with their partner.

An individual may value sex for both physical pleasure and relational intimacy. Thus these constructs are not mutually exclusive, but rather thought of as two separate dimensions. The relative value that a person places on sex for physical pleasure and/or relational intimacy can be understood as existing on a continuum from low to high; the interaction of these two continuums creates a dimensional matrix by which an individual's motivation to engage in sex can be plotted (Fig. 4.1). Thus these constructs are not mutually exclusive, but rather thought of as two separate dimensions. The model postulates that the relative value predicts sexual satisfaction following a challenge to their sexual relationship.

People who place a relatively low value on sex for physical pleasure and a relatively low value on sex for relational intimacy (Quadrant 3 in Fig. 4.1) most commonly feel indifferent or apathetic toward sex. They have little motivation to pursue sexual activity, as they tend not to find sex highly rewarding, either physically or emotionally. In the context of an intimate relationship, these individuals engage in sex primarily for the sake of their partner. When faced with sexual challenges, both men and women may find it exceedingly difficult to generate and sustain the motivation required to address and overcome sexual difficulties.

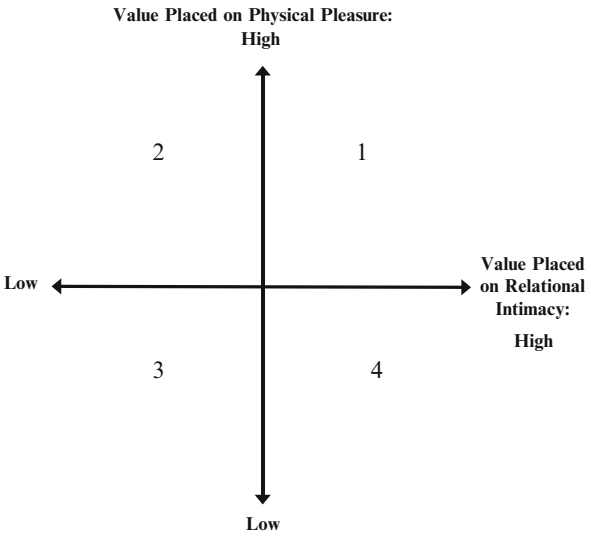

Fig. 4.1 Dimensional matrix of the value placed on sex

People who place a relatively high value on sex for physical pleasure and a relatively low value on sex for relational intimacy (Quadrant 2) engage in sexual activity primarily because of the physical gratification associated with sex. The main goal of sex is to have intercourse and experience orgasm. When paired with a partner who is willing and able to engage in sexual activity, these individuals often have healthy and satisfying sexual lives. When faced with sexual challenges however, these individuals most commonly become frustrated. Because these individuals place a relatively low value on sex for relational intimacy, sex with reduced physical pleasure, or in the absence of intercourse and orgasm, is unsatisfying. While they may be highly motivated to restore intercourse and orgasms, they often lack the flexibility to redefine their sexual relationships, to experiment with and place value in sexual activities other than intercourse and orgasm, to incorporate sexual aids, and/or to persevere through many months or years of sexual dysfunction.

People who place a relatively low value on sex for physical pleasure and a relatively high value on sex for relational intimacy (Quadrant 4) are motivated to engage in sexual activity primarily to feel emotionally close to their partner. These individuals often describe their partner as their best friend and maintain that intimacy in general is extremely important for the health of their relationship. They tend to be less concerned about the physical outcomes of sexual encounters (i.e., whether or not intercourse or orgasm occurred) but highly value the time spent together to focus on their partnership. For this reason, these individuals may respond to sexual challenges with less distress than those who place a high value on sex for physical pleasure. On an individual level, they are not overly concerned about specific sexual dysfunctions, but are motivated to find alternative ways of continuing to be sexually intimate with their partner, which may or may not include intercourse. These individuals often have a flexible attitude about the definition of sexual activity and are willing to experiment and take sexual risks with their partner.

People who place a relatively high value on sex for physical pleasure and a relatively high value on sex for relational intimacy (Quadrant 1) are motivated to engage in sex because it feels good and to emotionally connect with their partner. These individuals often engage in frequent and highly satisfying sexual activity with their partner. They also tend to describe sexual intimacy as important for the health of their relationship. When faced with sexual challenges, participants who highly value sex for both physical pleasure and relational intimacy are often tenacious about maintaining sexual intimacy. While they are willing to expand their definition of sexual intimacy, experiment, and take risks with their partner (and are able to derive sexual pleasure from these activities), they are also highly motivated to seek out, practice, and persevere with solutions to sexual dysfunction. These individuals often express a "just do it" attitude toward approaching and solving sexual difficulties.

Although the model is dynamic, assuming that couples' sexual values shift over time, Fig. 4.2 represents the researchers' estimations of each participant's relative value placed on sex for physical pleasure and/or relational intimacy. It is important to note that this graphical representation is an estimation based on the impressions

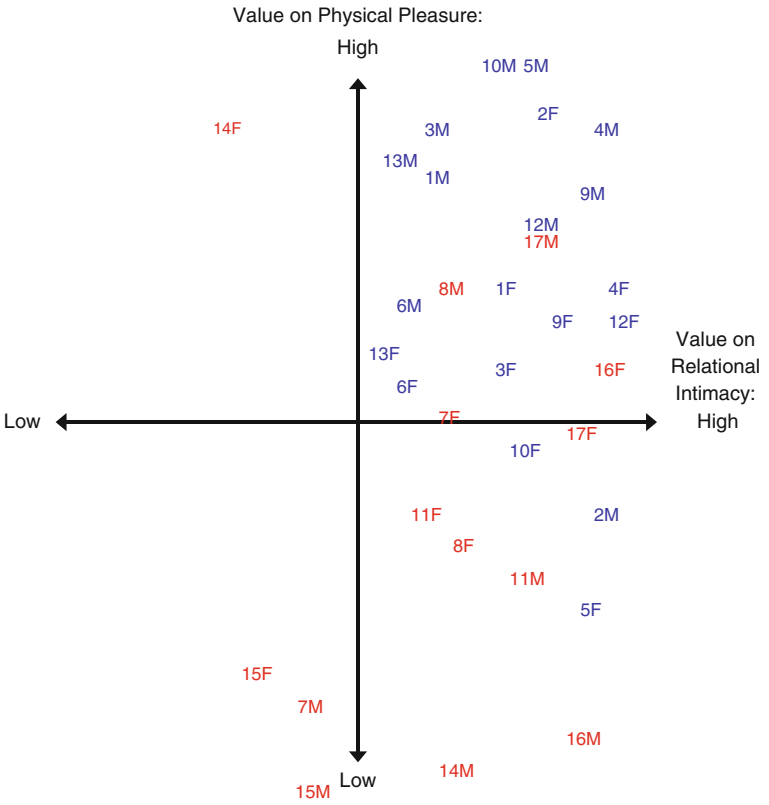

Fig. 4.2 Graphical representation of participants' relative value placed on sex for physical pleasure and relational intimacy. *Note*. Numerals represent couple identification numbers; "*M*" denotes male partner; "*F*" denotes female partner; *red* denotes those dissatisfied with current sexual intimacy; *blue* denotes those satisfied with current sexual intimacy

of participants' sexual values gleaned during the interviews. It represents the values of participants at one specific time-point and does not reflect the changes participants likely experience over time. Note that participants who reported satisfaction with their current sexual intimacy are denoted in blue, while participants who reported dissatisfaction with their current sexual intimacy are denoted in red.

An important aspect of the PRISM model is that the value that a person places on sex is dynamic, changing throughout a person's life based on sexual messages and sexual experiences, including events that challenge the sexual relationship. The interview data showed that individuals that struggle with sex, sometimes for many months or years, are able to restore satisfying sexual relationships after an honest assessment and reworking of their sexual values based on the new perspectives they gained from their experiences.

In addition to the fundamental importance of sexual values, the PRISM model found that several characteristics are often present in individuals and couples who are able to navigate challenges to their sexual relationships and maintain satisfying sexual intimacy (Beck et al., 2013). These characteristics include acceptance, flexibility, and persistence.

Acceptance Acceptance can be defined as the act of taking or receiving something offered. In the PRISM study, satisfied couples overwhelmingly acknowledged that it was important to take what they were given; in fact, this was an essential element of developing successful sexual relationships after being faced with an event that challenged the sexual relationship.

First, participants spoke of the importance of accepting the current situation. In other words, participants felt it was necessary to logically assess the situation they had found themselves in and, based on that assessment, develop realistic expectations about their current and future sexual relationship. The main sentiment was that continuing to rail against the current situation was a waste of emotional energy. When a person is able to set aside the frustration and the resentment, and instead accept the situation as it is, then one gains the intellectual and emotional resources needed to consider solutions and alternative ways of maintaining the sexual relationship. In this way, the PRISM model's notion of acceptance both accommodates and extends the ideas presented in the previous models: realistic expectations in the Good-Enough Sex Model, accepting one's sexual functioning (component 3) and addressing barriers to healthy sexual functioning (component 5) in the Sexual Health Model, and reducing the centrality of sexual functioning in the Flexible Coping Model (Metz & McCarthy, 2007; Reese et al., 2010; Robinson et al., 2011).

The PRISM model also extends the notion of acceptance by pointing out that because people often experience their sexuality in the context of a relationship, acceptance is also important in terms of one's own and one's partner's reactions to the sexual challenges and their feelings about potential solutions. First, an individual needs to acknowledge and accept their own feelings. For example, in the PRISM study, one woman had difficulty acknowledging that she was not satisfied with relational intimacy alone, but craved the physical pleasure associated with sex. Second, a person may need to work at accepting their partners' reactions to the sexual challenges and feelings. Whether one's partner is depressed and withdraws emotionally, is unrealistically optimistic about the future of the sexual relationship but complacent about taking action, is zealous and relentless about finding solutions, or seems unfazed by the experience, understanding and accepting a partner's feelings is a necessary but often challenging process.

Like the Good-Enough Sex Model (Metz & McCarthy, 2007), the participants in the PRISM study also needed to accept that emotional and physical sexual satisfaction was not all-or-nothing. In other words, successful couples were able to accept a sexual encounter that was "fair" or "moderate" as worthwhile and enjoyable. These couples seemed inherently to view sexual functioning as dynamic and fluctuating, with some sexual encounters better than others, but all meaningful and

worthwhile. This type of acceptance is particularly helpful in preventing hopelessness: a disappointing sexual encounter is not evidence that all future sexual encounters would be equally unsatisfying.

Flexibility Flexibility can be defined as the willingness or ability to modify or adapt. As understood in the context of the PRISM model, flexibility is the willingness to modify one's actions and reactions in the service of maintaining a satisfying sexual relationship. In order to successfully maintain satisfying sexual intimacy, couples must be willing to modify their old ways of having sex. This requires individuals and couples to experiment with new sexual activities and new sexual scripts. For example, couples may have to experiment with assistive aids, figure out how to have sex in a comfortable way, schedule sex rather than initiate spontaneously, and use manual stimulation or oral sex more frequently.

Second, successful coping requires flexibility in communication with one's partner. Many of the couples in the PRISM study had been intimate for decades and, prior to the challenges imposed by prostate cancer treatment, were used to a sexual routine that required very little explicit verbal communication. After treatment, however, it became imperative that partners verbalized their experiences before, during, and after sexual activity. In the absence of explicit communication, partners can be in danger of having unnecessary fears, experiencing discomfort, and misunderstanding their partners' feelings.

It is, again, clear that the PRISM model can accommodate the ideas presented in the existing models. The notion of flexibility, as outlined above, is congruent with the Flexible-Coping model, as well as component 1 of the Sexual Health Model (being able to talk openly and explicitly about one's sexual needs and desires) (Reese et al., 2010; Robinson et al., 2011).

Persistence Persistence is the act of continuing steadfastly in some purpose despite barriers or opposition. In the search for solutions to sexual challenges, sexually satisfied couples are incredibly persistent in obtaining information about possible solutions, approaching professionals for support, and experimenting and practicing with new ways of having sex until some satisfactory solution is found. For example, many of the dissatisfied couples in the PRISM study tried just one or two assistive aids only once or twice before giving up, while the satisfied couples were tenacious about trying an assistive aid many times in order to become comfortable and proficient with its use.

When considered in terms of an attitude, persistence appears to be made up of patience, determination, and perspective taking. Couples who are able to maintain sexual intimacy are patient, even when solutions to sexual problems take years to implement. They are determined that a sexual challenge was not going to stop them from enjoying one another sexually and they are able to engage in self-talk that helps them restore perspective when the challenges become particularly tiresome and difficult.

Summary of the PRISM Model

Sexual values can be integrated with the secondary themes of acceptance, flexibility, and persistence. Couples who strongly valued sex for relational intimacy were the ones who were most likely to exhibit these characteristics and successfully adapted to the challenges associated with prostate cancer treatment. Valuing sex for relational intimacy was what sustained couples, giving them the strength to accept their current functioning, remain flexible, and persist in finding solutions to events that challenged their sexual functioning.

This integrated theory of sexual resilience can be illustrated through a metaphor of a couple on a sailboat. The couple is navigating the sailboat out of a storm. On the hull of the sailboat is the name *Relational Intimacy* because, fundamentally, valuing sex for relational intimacy buoys sexual relationships through storms. There are three sails on the boat, one each for acceptance, flexibility and persistence, to illustrate that the couple's use of these attributes determines the specific direction or nature of their journey through sexual challenges.

Revisiting Sexual Motivation in View of Resilience

In general, research on sexual motivation is largely concerned with describing what motivates organisms to physically desire sexual activity, particularly intercourse. In other words, these theories concern themselves with the appetitive sexual drive. Many theories have been proposed, which include a plethora of components including approach/avoidance, appetitive/consummatory motives, excitatory/inhibitory brain processes, and those involving sensory/cognitive components (see Pfaus, 2008 for review). What these theories fail to explain, however, is why many people engage in sexual activity in the absence of the physical appetite for sex. In addition, these theories lead to the notion that low sexual desire is unnatural or unhealthy. An advantage of the PRISM model is that it can accommodate a broad range of levels of sexual desire that occur in healthy individuals and couples. This includes both individuals and couples that may happen to have a low desire for sex or feel that sex is not an important component of their relationship, in terms of fulfilling relational and/or physical needs.

The notion that people are motivated to engage in sexual activity for reasons beyond a desire to satisfy a sexual hunger has been strongly advocated (Basson, 2000, 2001, 2008). Basson has argued that, although the sexual response cycles developed by Masters and Johnson (1966) provided a substantial foundation for the understanding of the sexual response, the notion that sexual activity is consistently preceded by sexual desire is flawed and does not adequately account for the many motivators for engaging in sex. Instead, Basson posits that people may also engage in sexual activity for relational intimacy reasons, including emotional closeness, bonding, and commitment.

The fundamental reason that having high intimacy-based motivation helps couples maintain satisfying sexual intimacy may be that these couples are less invested in the physical outcome of sexual encounters than those who rely predominantly on sexual appetite as their primary motivation for engaging in sexual activity. Hence, these couples are more able to accept the challenges that arise, are flexible regarding solutions, and persist in continuing to engage in sexual activity despite difficulties. For these couples, because a primary reason for having sex is to experience relational intimacy, even if a sexual encounter is physically unsatisfying, the experience is still seen as emotionally satisfying and, therefore, not experienced as a failure. For this reason, these couples are more likely to experience resiliency rather than become caught in a negative feedback loop, where, in the event of a physically disappointing experience, all future sexual encounters are approached with the expectation of failure.

Dissatisfied couples, on the other hand, often wait for their own spontaneous sexual desire to arise before initiating sexual activity, or alternatively, wait for an invitation from their partner. The problem is that decreased physical desire is common during challenging times, and desire may rarely occur for both partners at the same time. Second, when the physical desire is present, the difficulties encountered in terms of sexual dysfunction (such as erectile dysfunction or dyspareunia) can eclipse the sexual appetite. In addition, couples who are motivated by physical desire are much more invested in the physical outcome of the sexual encounter and much more distressed in the face of physical challenges. In this way, a negative feedback loop occurs in which disappointing sexual encounters reduce the frequency and intensity of future sexual desires.

The Dynamic and Dimensional Nature of the PRISM Model

Individuals and couples invariably bring their pre-existing relationships, including sexual, into the experience of sexual challenges. Prior to these experiences, some individuals valued sex primarily for relational intimacy, while others primarily valued sex for physical pleasure. Some couples come into a challenging experience with good dyadic adjustment and strong constructive communication skills, while other couples are already experiencing tension and mutual avoidance. Facing sexual difficulties with a high value placed on sex for relational intimacy, with strong dyadic adjustment, and with effective and open communication skills primes a couple to respond well to sexual challenges. Our findings suggest that facing sexual difficulties with little value placed on sex for relational intimacy, with tenuous dyadic adjustment, and/or with an avoidant style of communication, may increase the likelihood of experiencing struggles in response to the sexual challenges. However, these trends likely do not automatically preclude couples from learning how to maintain or re-establish satisfying sexual intimacy. As the study findings suggest, some couples are able to overcome these challenges if motivated enough to maintain sexual intimacy. Based on this research as well as clinical observation, we have come to conclude that for some couples, the sexual challenge, when handled

well, can become a vehicle not only for improving sexual intimacy but also for addressing longstanding relationship issues and for deeper emotional healing.

An important aspect of the dynamic and dimensional nature of the PRISM model is that it accounts for the process of adjustment that couples experience after sexual difficulties. Because an individual's experience is dynamic, so too is his or her placement on the model. As individuals struggle with their new and challenging sexual relationship, they may go through a process of self- and partner-reflection as a way of searching for solutions. This may include a re-evaluation of their motives for engaging in sex. Through this process, some people who initially struggled may be able to develop a new appreciation of relational intimacy. Although some couples may remain entrenched in their maladaptive communication styles and weak dyadic adjustment, other couples that are initially frustrated may progress and became more satisfied over time.

The PRISM model reflects and can accommodate these movements, as couples learn to value relational intimacy through practice. Although the degree to which individuals and/or couples are able to adjust their sexual values is not known at this time, the interview data suggest that change is possible and that couples appear to be able to move within the model. Several couples, in describing their sexual experiences before, during, and after prostate cancer, made comments that suggested that their sexual values had changed over time. This was sometimes due to relationship factors (e.g., the individual had changed partners, and the newer partner's values influenced a change in their sexual values). At other times, a change in sexual values was an outcome of searching for new perspectives and solutions for the couple's struggling sexual relationship. Further research on and clinical application of the PRISM model will provide more information about the degree to which sexual values are modifiable.

Another important aspect of the dimensional nature of the PRISM model is that it allows for the assessment of degree. That is, those who happen to fall into the same general category or quadrant are not assumed to have the same level of that particular value. For example, two couples may express satisfaction with their current sexual relationship, and both may place a relatively high value on sex for relational intimacy and for physical pleasure. However, the model allows for the two couples to differ in degree. One couple may fall into the far reaches of the upper right quadrant, while the other couple may settle near the axes. Furthermore, individual partners within the same couple may differ in their sexual values. Discordant values (e.g., apathy vs. high motivation) may contribute to more struggles. Fundamentally, the PRISM model can account for variations in appraisal of the sexual experience (i.e., not everyone is satisfied, frustrated, or apathetic to the same degree).

Clinical Implications

The field of sexuality lacks a comprehensive model to guide effective clinical interventions. For example, current intervention programs designed to improve couples' sexual satisfaction after prostate cancer have yielded disappointing results

(Canada, Neese, Sui, & Schover, 2005; Chambers, Ferguson, Gardiner, Aitken, & Occhipinti, 2012; Collins et al., 2013; Giesler et al., 2005; Manne et al., 2011; Schover et al., 2011). These interventions emphasize strategies for restoring erections and thus for increasing physical pleasure. The PRISM model suggests that the reason these interventions produce disappointing results is that they may inadvertently encourage couples to value sex mainly for physical pleasure (Canada et al., 2005; Schover et al., 2011). This idea is also supported by the literature suggesting that those couples who re-negotiate their sexual practices and are willing to incorporate more non-penetrative activities (Reese et al., 2010; Wittmann et al., 2009) or even non-traditional penetrative activities (e.g., strap-on dildo; as described in Warkentin, Gray, &Wassersug, 2006), into their sexual repertoire, are likely to succeed in maintaining satisfying sex.

The PRISM model helps us understand the relationship between flexibility and a couple's shared values. When couples first try new ways of being sexual, for example by using a pro-erectile aid like a PDE5i, they usually find that sex is not as physically pleasurable as before. Couples who value sex predominantly for physical pleasure can become demoralized when they find sex to be less physically pleasurable. Couples who also value sex for relational intimacy find sex with less physical pleasure to still be rewarding because they value the time spent being physically intimate.

We have started to use a values clarification exercise based on the PRISM model in our clinical work with couples experiencing sexual dysfunction subsequent to prostate cancer treatment with promising results (Hampton, Walker, Beck, & Robinson, 2013). The PRISM model appears to have an appeal for couples by helping them to clarify their own sexual values and better understand those of their partner. We now return to the couple we introduced at the beginning of this chapter to illustrate the model's clinical utility:

Joan and Rick sought counseling after struggling with their sex life for over 2 years after Rick's surgery for prostate cancer. They had married in their mid twenties. Now, with their three children out of the house and without the stress of work, they looked forward to enjoying each other's company, especially sexually.

Joan and Rick were a fairly typical couple. While they both enjoyed sex over the course of their relationship, it was never a central part of their marriage. Consequently, they were both surprised to find how their sexual difficulties were disrupting their relationship in such profound and pervasive ways. Rick had completely lost the ability to get an erection after his surgery. To their amazement, Rick was still able to get sexually aroused and reach orgasm (albeit dry) without an erection. Their surgeon said that Rick's erections would improve with time and if they didn't, he would prescribe Viagra. Rick's erections had improved but even with Viagra he couldn't reliably get an erection hard enough to have enjoyable intercourse. Despite their best efforts to find a way to enjoy intercourse like they did before surgery, they couldn't. Their love making changed. Now, if Rick got an erection they hurried to have intercourse before he went soft. Rick felt that he was letting Joan down by not being able to perform and became hesitant to approach her even though he longed just to be held by her. Joan didn't want to put pressure on Rick, so she held back on giving Rick anything more that perfunctory hugs and

kisses for fear he would think she was wanting intercourse. Their hearts ached for one another. They felt desolate and demoralized as individuals and as a couple because they couldn't see a way to make things better.

The counselor gave Joan and Rick the following instructions:

Print out 2 copies (*see* Figure 4.1) *of the* ***P****hysical* ***P****leasure t* ***R****elational* ***I****ntimacy Model of* ***S****exual* ***M****otivation* (*PRISM*) *form, one for each of you.*

On your own, first think about how much you value sex for physical pleasure. Put an ***X*** *on the* ***vertical*** *line to indicate the degree to which you value sex for physical pleasure. If you highly value sex for physical pleasure put your X close to the top of the line. If you don't value sex for physical pleasure put your* ***X*** *closer to the bottom of the line.*

Do the same thing thinking about how much you value sex for relational intimacy. This time draw your ***X*** *on the* ***horizontal*** *line.*

Draw lines to connect the two lines and write your name where the two lines intersect.

Now do the same thing guessing how your partner filled out the form and put your partner's name beside the point.

Show each other how you filled in the form.

When the couple saw how the other filled in the grid, the couple's dispirited demeanor changed to one of excitement as they began to talk directly to one another rather than to the counsellor. Rick saw that Joan greatly valued sex for relational intimacy but only minimally valued sex for physical pleasure. Joan saw that Rick valued sex highly both for physical pleasure and relational intimacy, but relatively less so for relational intimacy.

Joan reminded Rick that sex had never been all that physically pleasurable for her and since menopause even less. She went on to say that for her, sex was a special time when they shut out the world and just focused on one another trying to make each other feel special. She teared-up when she saw how much Rick valued sex for physical pleasure, "*I now understand why the loss of your erections troubles you so much. And I now understand that you keep trying to make sex more physically pleasurable for me because that's what you value most about sex.*"

Rick explained that he did value sex for relational intimacy, but because he actually felt closer to Joan when they were listening to a beautiful piece of music or hiking in the mountains, sex was less important for him as a way of being emotionally intimate with Joan. For him, there was nothing that physically felt better than sex. Rick sighed "*I have to accept that sex will never feel the way it did before surgery.*" *He went on to say how he now realized that his single-minded efforts to make sex more physically pleasurable for both of them resulted in their focusing more on helping him have an erection and having intercourse, and less and less on one another.*

Having the exclusive goal of trying to make sex more physically pleasurable left both of them feeling desolate and disappointed after sex. With this insight, they then began to talk about how they could start to focus more on one another and re-establish a sense of intimacy in their love making.

Application of the PRISM Model to Other Populations

While the PRISM model was developed based on research with couples after prostate cancer treatment, the theory need not be restricted to this population. It is possible that the model may be applicable to a variety of couples who have experiences that present a challenge to healthy sexual functioning. The model may also be able to potentially predict outcomes for couples just facing a sexual challenge, as the PRISM model suggests that the main motives for engaging in sexual activity (for physical pleasure and/or relational intimacy) are likely a determining factor in the successful maintenance of satisfying sexual intimacy in the face of general challenges.

The PRISM model's potential wide-ranging applicability may be due, in part, to its relatively general nature in that it does not pre-suppose prostate cancer (PrCa)-related struggles per se. It is likely that the model is applicable to a wide range of individuals and couples struggling with many types of sexual challenges, either primary sexual dysfunction or sexual dysfunction secondary to other problems such as cancer, other health issues, disability, mental health challenges, and even relationally-based difficulties.

For example, the PRISM model may be applicable to other cancer populations. Breast cancer itself, as well as its treatment, is associated with sexual dysfunction for women (see Henson, 2002, for review; Krychman & Katz, 2012). With the presence of diminished libido, pain with intercourse, depression, fear of rejection, or fatigue, the motivation to engage in sexual activity for physical pleasure may place a heavy burden on women, who may react by shying away from sexual encounters with their partner. However, with the reconsideration of sex as an activity whose goal is to relate intimately with one's partner, rather than perform physically or experience physical pleasure, sexual activity may become less threatening to women, and they may be more likely to continue their sexual relationships.

The PRISM model may also be applicable to individuals with chronic illnesses (e.g., diabetes), disabilities (e.g., spinal cord injury), or age-related changes and diseases (e.g., cardiovascular disease, hormonal changes). These types of health challenges cause stress, as well as specific sexual side-effects, such as erectile dysfunction and vaginal dryness. The PRISM model has potential utility with such populations as well, as these individuals can continue to find value in and benefit from sexual activities with their partner, even when their disability precludes them from performing the full range of activities normally associated with sex (i.e., intercourse, orgasm, etc.). When the physical pleasure aspect of sex is viewed as an enjoyed, but not essential, component of sex, couples no longer need to rely on perfect sexual functioning to engage in satisfying sex. Physical pleasure can come to be seen as "icing on the cake", while relational intimacy is the cake itself.

Moving even further from the realm of health challenges, it may be possible to adopt the PRISM model as a lens through which to understand and assist individuals who are struggling with sexual challenges secondary to other experiences, such as the birth of a child, relationship breakdown, or chronic stress. Asking individuals

or couples to reflect on the reasons they value sex and to determine in what ways their current sexual relationship is meeting their needs, and failing to meet their needs, could allow the couple to begin renegotiating their sexual repertoire to create a relationship that is more satisfying to both. As some of these examples suggest, we believe that the PRISM model is inclusive and nonspecific enough to generalize to a wider population and to have clinical utility for a range of sexual challenges.

Future Research Directions

Future research stemming from the PRISM model could take several forms and follow a variety of paths. First, similar studies could be carried out with other populations to test whether the model appears valid for other types of people struggling with other types of sexual challenges. For example, similar studies could be carried out with homosexual couples after PrCa treatment or with couples after other types of cancers, health concerns, or disabilities. In addition, it is possible that the relative value one places on sex may change with age and stage of the relationship, and this could also be tested.

The model's predictive validity could be tested by interviewing couples before a known challenge, such as PrCa treatment, and having individuals place themselves on the model pre-treatment. Using this information, it may be possible to predict couples' likely outcomes, given the specific sex-related struggles of the specific challenge. Couples actual outcomes could then be compared with their predicted outcomes. The model would certainly gain strength and validity if it could be shown to hold up to this type of prediction.

Another future research endeavor would be to develop a measure that could place individuals and couples on the model of sexual values. The measure could be tested first on PrCa populations for reliability and validity. Once a valid and reliable measure was created, normative data could be gathered and generated for non-PrCa populations. Taking this line of research further, given a valid and reliable measure, one could then test the measure on other populations of individuals struggling with sexual challenges, to test whether the model appears valid for other populations.

If the model constructed and presented here is able to stand the test of time, given research and debate, it is possible that one could develop a psychotherapeutic intervention in order to help couples maintain sexual intimacy and thus demonstrate sexual resilience in the face of sexual challenges. This intervention would be theoretically based on the model and tested using pre-post measures of one's sexual values. Specifically, one could test whether those in the intervention group were more successful at maintaining sexual intimacy than those in the control group. One could also test whether individuals can and do modify their sexual values with intervention.

Summary

Our initial research question was, how are some couples able to demonstrate sexual resiliency and maintain a satisfying sexual relationship after the challenge of prostate cancer treatment, while other couples are not? The PRISM model was developed using grounded theory methodology. The model suggests that those couples who value sex for relational intimacy will be more likely to maintain or re-establish satisfying sexual intimacy, when faced with a challenge to their sexual relationship. Acceptance, flexibility, and persistence are characteristics most commonly associated with couples who successfully negotiated the challenges to their sexual relationship.

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Chapter 5
Dyadic Adaptation to Chronic Illness: The Importance of Considering Context in Understanding Couples' Resilience

Kristi E. Gamarel and Tracey A. Revenson

The concept of resilience is typically defined as positive adaptation under adverse circumstances (Luthar, Cicchetti, & Becker, 2000). This definition derives from work in human development that focused on how children could develop normally or even thrive under adverse family and social circumstances, including poverty, neglect, abuse, and chronic illness (e.g., O'Leary, 1998; Werner & Smith, 1977). More recently, research on resilience among adults continues to examine positive life changes under adverse situations, focusing on both outcomes and process (Bonanno, 2004; Danoff-Burg and Revenson, 2000; Joseph & Linley, 2005; Lepore & Revenson, 2006; Park & Helgeson, 2006; Tedeschi, Calhoun, & Cann, 2007; Tennen & Affleck, 1998). This phenomenon also has been referred to as stress-related growth, posttraumatic growth, thriving, and benefit-finding.

In truth, no single definition fully captures the construct of resilience. Resilience has been conceptualized as an outcome when it is viewed as an endpoint of stress and coping processes. It has been conceptualized as a personality attribute or coping resource (Aspinwall & Taylor, 1997; Carver, Scheier, & Segerstrom, 2010). And it has been conceptualized as a process involving dynamic interactions between risk and protective factors that can be within (e.g., biology, personality) or outside (e.g., social support) of the person (Bonanno, 2004; Luthar et al., 2000; Masten & Coatsworth, 1995; Rutter, 1985, 1999). Whichever approach is adopted, researchers have increasingly examined this phenomenon in the context of adverse health conditions, particularly cancer (Park, Lechner, Antoni, & Stanton, 2009).

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In this chapter, we expand the construct of resilience to the dyadic or interpersonal realm, specifically to couples that exhibit resilience in the face of a particular medical challenge: HIV disease. We couch resilience in a dyadic coping framework (Revenson, Kayser, & Bodenmann, 2005), in which each partner's stress appraisals and coping effects mutually influence individual and couple-level outcomes. We chose HIV disease as an exemplar because unlike many other illnesses (e.g., cancer), the consequences of coping with the illness affect partners' health and well-being; that is, dyadic coping not only affects psychological adjustment to the illness but also physical health: the virus can be transmitted between partners if dyadic coping is not effective.

Scholars have increasingly noted the difficulty of individual-level HIV prevention interventions, and called for research that examines the social, relational and structural contexts of people's lives that sustain risk behavior or promote optimal health behaviors (Beyrer et al., 2012; Diaz & Ayala, 2001; Huebner, Mandic, Mackaronis, Beougher, & Hoff, 2012). As a large proportion of HIV risk behavior occurs within the context of a primary romantic relationship (Davidovich et al., 2001; Dolcini, Coates, Catania, Kegeles, & Hauck, 1995; Marin, Tschann, Gomez, & Kegeles, 1993; McCoy & Inciardi, 1993; Reilly & Woo, 2004; Sullivan, Salazar, Buchbinder, & Sanchez, 2009; Weinhardt et al., 2004), researchers have sought to examine how relationship dynamics contribute to risk behaviors, both within and outside the primary partnership among same-sex male couples (Hoff, Beougher, Chakravarty, Darbes, & Neilands, 2010; Mitchell, Harvey, Champeau, & Seal, 2012; Prestage et al., 2008). In this review, we first focus first on definitions of dyadic coping. Then, we systemically review the literature on dyadic coping among same-sex male couples in which one or both partners has HIV disease. We conclude with a roadmap for future investigations, arguing for a greater attention to the questions of mechanism and context that are critical for examining dyadic resilience and health among gay male couples affected by HIV.

Dyadic Resilience and Dyadic Coping

Our conceptualization of dyadic resilience starts with Lepore and Revenson's (2006) tripartite model of three related – yet distinct – definitions of resilience in the face of stress and adversity: Recovery, Resistance, and Reconfiguration. *Recovery* is similar to standard definitions of adaptation to stress (Stanton, Revenson, & Tennen, 2007). When a stressor disrupts a person's normal state of functioning, the individual appraises and copes with the stressor with the goal of returning to pre-stressor functioning. *Resistance* (called recovery by Bonanno, 2004) is used to describe individuals who appear not to be severely affected by a stressor and maintain their "normal" functioning during and after a stressor. Resistance is seen by some as pathological as individuals do not visibly exhibit distress (see Bonanno). *Reconfiguration* is where individuals confronting adversity are able to reconstruct the experience in terms that either change their world views or reframe the stressor

to fit into an existing world view (Janoff-Bulman, 1992). In all three definitions, resilience is not conceptualized as a static personality trait (i.e., a person is resilient or not); instead, it is a dynamic process in which people, or in our case couples, may show better adjustment outcomes at different times.

A good deal of research shows that when one member of a couple faces a serious chronic illness, both partners are affected (Bodenmann, 2005; Revenson & DeLongis, 2011). In some cases, the well-partner's mental health is affected to a greater degree than the patient's (Fagundes, Berg, & Wiebe, 2012; Manne, Badr, Zaider, Nelson, & Kissane, 2010; Milbury, Badr, & Carmack, 2012). Among couples affected by chronic illness, a supportive intimate relationship may protect against the social and psychological stressors of illness that give rise to poor mental and physical health outcomes (Stanton et al., 2007). Moreover, relationship variables are important and independent predictors of optimal coping efforts and positive health outcomes, over and above the presence of general perceived social support (Berg & Upchurch, 2007; Bodenmann, 2005).

Although a central component, the concept of dyadic coping involves much more than the transaction of social support. Individuals whose partner has chronic illness "occupy a dual role in the coping process: as a primary provider of support to the ill partner, helping him or her cope, and as a family member who needs support in coping with the illness-related stressors she or he is experiencing" (Revenson, 2003, p. 533). At the same time, although a large number of studies, including prospective population studies, have established strong associations between intimate relationships and health outcomes, increases in social support are not always protective (Revenson & DeLongis, 2011). For example, unwanted social support can produce relationship conflict, maladaptive coping, increased negative affect, and poorer disease progression (Revenson & DeLongis).

In the context of chronic illness, scholars have suggested that couples who are able to adopt a dyadic perspective or "we" orientation in relation to illness demonstrate an increased capacity to cope (Badr, Carmack, Kashy, Cristofanilli, & Revenson 2010; Berg & Upchurch, 2007; Fergus, 2011; Skerrett, 1998) and what we might call greater resilience. In synthesizing the existing literature on couples adaptation to chronic illness, Fergus (2011) noted that the variety of ways couples potentially interact as they manage illness-related stressors have been termed many different constructs, including "dyadic coping" (Bodenmann, 2005), "communal coping" (Lyons, Michelson, Sullivan, & Coyne, 1998), "coping congruence" (Revenson, 2003), "collaborative coping" (Berg et al., 2008), "joint platform" (Salander & Spetz, 2002), and "we-ness" (Skerrett, 1998). However, the comparable feature across these constructs is the recognition that illness is a shared health threat that affects both partners and that coping (e.g., managing or minimizing distress or accepting circumstances) is a joint responsibility rather than individual efforts (Fergus). There is also some evidence that when couples cope in a congruent fashion (using either similar or complementary coping strategies), adjustment to illness is increased (Revenson, 2003), although the nature of the coping is key: In a study of metastatic breast cancer patients and their partners, congruence in coping was beneficial when it was focused on joint problem solving and not mutual avoidance (Badr et al., 2010).

Dyadic Coping with HIV Disease

Theories in relationship science and dyadic coping offer useful frameworks for understanding the mechanisms of couples' coping with illness by examining how partners' cognitions, emotions and behaviors mutually influence each other while being interdependent (Bodenmann, 2005; Lewis et al., 2006; Mermelstein & Revenson, 2013). More recently, a call has been made to broaden approaches to HIV prevention efforts to address not only social, psychological, behavioral, and biological factors, but also examine the interpersonal factors that are associated with HIV transmission and adaption to illness (El-Bassel & Remien, 2012; Karney et al., 2010). Until recently, few HIV researchers focused on couples (Burton, Darbes, & Operario, 2010). Also ignored are relationship factors, such as intimacy and trust, and the sociocultural context, such as social stigma or heterosexism.

In our review of research on "dyadic resilience", we decided to address key questions about how social support, relationship factors, and dyadic coping could help us understand resilience among same-sex male couples in which one or both partners are living with HIV and to use that research evidence to understand dyadic resilience more generally. In this context, dyadic resilience is broadly defined to be inclusive of couples' resources, dyadic coping efforts and the ensuing mental and physical health outcomes as well as relationship "health". We conceptualize dyadic resilience as an iterative process in which couples draw on their resources and past dyadic coping strategies in the face of a recurring stressor or a new stressors to ensure positive dyadic outcomes (Dunkel Schetter & Dolbier, 2011).

What might resilience look like among same-sex male couples where one or both partners are living with HIV? We believe that resilience may involve the ability to remain emotionally close and mutually supportive despite the potential of HIV transmission and other stressors such as HIV stigma and gay-related discrimination. Within HIV serodiscordant couples, this would also include maintaining sexual intimacy, open communication, and relationship quality while having to navigate safe sex practices. We were interested in reviewing existing literature to examine whether and how relationship factors served as potential dyadic resilience resources. We were also interested in the degree to which the sociocultural context of HIV shaped dyadic resilience.

Methods of the Systematic Review To answer these questions we conducted a systematic review of the literature. Briefly, articles were identified through searches conducted on MEDLINE, PubMed, PsychInfo, CINAHL, and Social Sciences Index using a combination of the following search terms as key words and in abstracts: *HIV or AIDS* or *Acquired Immunodeficiency Syndrome* and *couples* or *family characteristics* or *caregivers* and *gay* or *homosexual*. The initial search yielded 206 unique articles published from 1986 to 2012. Articles were included in the review if they were original research; collected data from both members of a couple; and couples were biological males in a romantic relationship with another biological male in one or both of the partners had HIV/AIDS. Only 27 (13 %) articles met these criteria. It is worth noting that multiple articles were published

from the same data set. In total, only 16 articles were unique studies and the remaining 11 used data from 4 data sets (but examined different research questions). We coded the studies along multiple dimensions including study approach (whether the study used a theoretical framework and what it was), relational variables (duration, partners' HIV serostatus), study design (cross-sectional or longitudinal, intervention or observational, qualitative or quantitative), and outcome (sexual risk behavior, medication adherence, psychological adjustment). Aspects of the sociocultural context, when available, included measures of HIV stigma, heterosexism, and minority stress (Meyer, 2003).

This systematic search yielded a relatively small body of literature comprised of studies that were largely cross-sectional, self-report and including couples that varied widely in relationship duration (3 months to 27 years). Thus, a few caveats are in order: First, although all 27 articles included data from both members of the couple (an inclusion criterion), less than half (13 or 48 %) analyzed the dyad as the unit of analysis, and only four used a statistical analysis technique such as the actor partner interaction method (APIM) that accounts for intradyadic interdependence among the measures. About two-third of the studies (18) combined couples of different serostatus (i.e., discordant, concordant negative, and concordant positive) in analyses and over half (19) failed to include information about the length of time since the HIV diagnosis.

Organization of the Review The broader literature examining couples coping with chronic illness suggests that partners mutually experience the stresses of one partner's illness, and that relational factors may moderate the relationship between stressors and health outcomes. Couples draw on the quality of their relationship to engage in effective dyadic coping (Berg & Upchurch, 2007; Coyne & Smith, 1991; Hagedoorn et al., 2000). Examining the outcome of sexual risk behavior, treatment adherence, substance use and psychosocial adjustment, we divided the review into three sections that address: (1) social support and community integration; (2) intimacy, trust, and commitment; sexual agreements; and (3) power and equality. Whenever possible, we note whether the samples are seroconcordant or serodiscordant and whether serostatus affects the findings. After reviewing the literature, we examine how these processes contribute to dyadic resilience.

Social Support and Community Integration

Although less than half of the 27 articles used a theoretical framework, the 12 articles that did were studies of how social support affects sexual behavior, adherence, or psychological adjustment. Social support often has been used as an umbrella term for a number of aspects of social relationships (Revenson & DeLongis, 2011). Reflecting this, the articles in our review used vastly different definitions and measurements of supportive relationships. HIV-specific social support refers to functional elements of social support, such as reminding, encouragement, informational and emotional support exchanges from close relationships (Wills & Ainette,

2012). Because they experience rejection and discrimination, many gay men may not be able to turn to their families and communities of origin to obtain support (Fergus, Lewis, Darbes, & Butterfield, 2005). As a result, gay men have historically created "families of choice" to develop a positive sense of identity and well-being. Similarly, integration into and identification with the gay community has been posited to "foster a positive sense of identity that may counter the mental and physical health effects of heterosexism and homophobia" (Fergus et al., 2005, p. 152). Gay community integration has been assessed within the broader literature to include a variety of activities such as "participation in specific gay or bisexual functions or activities; belonging to gay or bisexual organizations; reading gay books, magazines, and newspapers; patronizing gay shops or businesses; or going to gay bars, dances, or clubs" (Fergus et al., p. 152; see also Kippax et al., 1992; Rosario et al., 2001).

Community Integration Two studies of 59 gay male couples (37 seroconcordant negative, 7 seroconcordant positive, and 10 serodiscordant) suggested that community integration was associated with *increased* sexual risk behavior (Fergus et al., 2005; Fergus, Lewis, Darbes, & Kral, 2009). Frequenting gay bars was associated with greater sexual risk behavior among *both* partners (Fergus et al., 2005). Subsequent analyses found that there was significant actor effect, such that higher level of gay community integration was associated with a 2.3 increased odds of engaging in sexual risk behavior (Fergus et al., 2009). However, this was qualified by a significant interaction such that participants who reported high levels of general social support and low levels of community engagement reported less sexual risk behavior, whereas partners with high levels of support but high levels of community engagement reported a greater probability of sexual risk behavior. It should be noted however, that the measure of support was of perceived support without specifying a source so it is unclear if partner support is protective. Nonetheless, this study suggests that community integration within the gay community may be an important factor for understanding sexual risk behavior among same-sex male couples.

Social Support Studies of social support have focused on different health outcomes. In a qualitative study, Wrubel, Stumbo, and Johnson (2008) examined three different types of support for medication adherence among same-sex male couples: reminding, medication support (monitoring medications, and organizing, ordering and picking up refills), and coaching. The frequency of each type of support reported did not differ by couple HIV serostatus and were described as evidence of caring. For example, one man described how his partner nags him to take his medications stating "That's fine. I'll just get annoyed with him nagging then take it just so he'll shut up [chuckles]" (Wrubel et al., 2008, p. 854). In contrast to this quote, the authors described how many of these support transactions were 'invisible' forms of support (Bolger & Amarel, 2007; Bolger, Zuckerman, & Kessler, 2000) that went unnoticed by the partner. According to research by Bolger and his colleagues, invisible support may be more effective because visible forms of support can produce feelings of dependency and indebtedness. However, these types of support were not linked to outcomes within this study.

Darbes and Lewis (2005) found that after statistically controlling for levels of general support, HIV-specific support from partners around safer sex behaviors was associated with a reduced odds of engaging in risk behavior. This finding did not differ by couples HIV serostatus. However, HIV-positive partners who reported greater levels of general social support had *increased* odds for sexual risk behavior with partners of the same serostatus *outside* the relationship. The authors interpret these findings as a function of serosorting practices, which refers to "a partner selection strategy whereby sexual partners are chosen on the basis of their HIV status" (Eaton, West, Kenny, & Kalichman, 2009, p. 185). By serosorting, one can choose sexual partners of the same HIV status for the primary purpose of having unprotected sexual acts (Eaton et al., 2009). Eaton and colleagues (2009) found that men in sero*con*cordant relationships (i.e., whether both partners were HIV-negative or HIV-positive) were more likely to believe that serosorting reduced HIV transmission risk, compared to men in serodiscordant relationships. As such, there may be different perceptions of health threats and the efficacy of social support based on the couple's HIV serostatus that require future examination.

In sum, few studies examine the relation between social support – broadly defined – and health outcomes for same-sex male couples. There is some evidence that gay community integration may influence risk behavior among men in same-relationships (Fergus et al., 2005). Partners' exchange of domain-specific support in the context of adherence and sexual risk behaviors may serve important functions for the recipient, the provider, and the relationship (Darbes, Chakravarty, Beougher, Neilands, & Hoff, 2012; Wrubel, Stumbo, & Johnson, 2010). Because the studies use different conceptualizations and measures of support, examine different health outcomes, and have small sample sizes that may not be representative, it is difficult to draw strong conclusions. Moreover, it is not clear whether there are differences between seroconcordant and serodiscordant couples, which may be essential for creating interventions to reduce risk behaviors.

Intimacy, Trust, and Commitment

Regardless of sexual orientation or serostatus, a number of studies have found lower condom use reported among intimate partners compared to casual partners. Although HIV prevention efforts tend to emphasize multiple and concurrent casual partners (Grov, Parsons, & Bimbi, 2007; Mimiaga et al., 2009), studies have found that feelings of intimacy, trust and commitment in intimate relationship are associated with greater intra-dyadic risk behavior (Theodore, Duran, Antoni, & Fernandez, 2004) and that serostatus is a key contextual variable in these findings.

The symbolic meaning of condom use may be particularly pronounced among men in serodiscordant relationships. In an early study, Remien, Carballo-Dieguez, and Wagner (1995) examined facilitators and barriers to condom use among 15 same sex male couples, conducting separate focus groups for HIV-positive and HIV-negative partners. Men often described condom use as a barrier to emotional

intimacy, and condoms were seldom used for oral or anal sex. Because the HIV-positive and HIV-negative partners wanted to protect each other from thinking about transmission, communication about condom use was curtailed and actual condom use suppressed in order to circumvent fears about illness progression and transmission risk. In fact, for some men, condom use became a constant reminder of the couple's serodiscordant status. Moreover, positive relationship adjustment was actually found to increase risk behavior, such that some men also reported that as emotional intimacy, security and trust grew with their partner, and as familiarity and length of time in the relationship increased, their perception of transmission risk decreased and unprotected sex increased.

Over a decade later, Nieto-Andrade (2010) examined the association between awareness of transmission risk and sexual behavior in a qualitative interview study of 44 men in serodiscordant relationships. Both HIV-positive and HIV-negative men who felt a greater sense of commitment to their partner *didn't* use condoms with that partner. Specifically, men who reported unprotected sex described their relationship as long lasting and that they were not afraid of becoming infected with HIV. Some men reported that not wearing condoms was a way to minimize relationship conflicts and feel connected to their partners. For some HIV-negative men, not wearing a condom was described as a way of showing love and commitment to their partners and illustrating that they were not afraid of infection. However, approximately one-quarter of both the HIV-positive and HIV-negative men in the study reported that avoiding infection or re-infection was based on commitment to the relationship, and that condom use was a mutual responsibility in which both partners faced the transmission threat together.

Summarizing across these studies we can conclude that although some men conceptualized safe sexual behaviors as a way to show their love and commitment to their partner, the drive for intimacy may overshadow rational decision-making during emotionally heightened sexual encounters. Thus, there may be an underlying belief among many same-sex male couples that condoms are antithetical to intimacy, and that having unprotected sex with their partners connotes an act of intimacy through which they express their commitment to their partner.

Sexual agreements involve the decisions couples make about whether they allow sex with outside partners and the sexual behaviors they engage in together (Hoff & Beougher, 2010; Hoff et al., 1997, 2009). Originally termed 'negotiated safety' (Kippax, Crawford, Davis, Rodden, & Dowsett, 1993), investments in sexual agreements are seen as an important relationship factor associated with reduced sexual risk behaviors among gay male couples (Hoff et al., 2009).

Although investments in sexual agreements are a way for partners to protect one another from HIV transmission (Neilands, Chakravarty, Darbes, Beougher, & Hoff, 2010), they are not often motivated by HIV prevention beliefs. For example, Hoff and colleagues (2009) examined similarities in motivations for sexual agreements across 566 gay and bisexual couples of different HIV serostatus (concordant negative, concordant positive and discordant). The primary reasons for making sexual agreements were to promote honesty and trust. Better relationship quality

(i.e., intimacy, trust, commitment, attachment and equality) was reported by men in monogamous relationships than by men in an open relationship or men whose partners did not hold the same views on their sexual agreement. In fact, men in discrepant relationships had the poorest relationship quality of all the relationship groups, and endorsed greater avoiding and withholding communication. These findings suggest that mutual decision-making and open communication around sexual agreements are important for building trust and honesty, which may reduce transmission risk.

Violations of sexual agreements are not uncommon and have the potential to produce strain on the relationship, placing the couple at risk for HIV and other sexually transmitted infections (Hoff et al., 2009). Hoff et al. (2010) analyzed in-depth qualitative interviews with 39 gay male couples (17 concordant negative, 10 concordant positive, and 12 discordant) about their sexual agreements. For some couples, taking emotional breaks – that is, continuously having sex with new partners without thinking about their partner's reactions created emotional distance – violated "trust, intimacy, and, commitment, and in some cases threatened the longevity of the relationship" (Hoff & Beougher, 2010, p. 782). Other couples who had explicit agreements that allowed sex with outside partners placed conditions on these agreements "to separate physical and emotional intimacy with outside partners or to not have ex-boyfriends as outside partners" (Hoff & Beougher, p. 782). These types of breaks, however, threatened the relationship and increased risk for HIV transmission. Hoff and colleagues (2010) found that of the 25 breaks reported, 21 were disclosed to the partner, perhaps because communication about the break offered a way to renegotiate their needs and desires. In contrast, the few men who did not tell their partner that they had broken the sexual agreement reported emotional distance from their partner. Disclosure and communication about breaks is a critical relational variable to consider in dyadic coping within HIV affected couples, as it has a significant impact on the relationship and sexual health of each partner and of the "health" of the relationship.

Couple HIV serostatus is an important contextual factor in the underlying reasons for sexual agreements. For example, an HIV diagnosis had a major impact on the sexual relationship in a small study of ten gay male couples in serodiscordant relationships (Palmer & Bor, 2001). As a result of the diagnosis, all the couples had explicit sets of rules for sexual agreements, which ranged from open to closed to no sexual activity. Hoff and Beougher (2010) found that men in serodiscordant relationships reported the "most articulate and detailed agreements, including the specific behaviors they could engage in with each other and with outside partners" (p. 785). This suggests that sexual agreements among couples in discordant relationships may constitute a relationship maintenance mechanism. In Palmer and Bor's (2001) study, only two of the HIV-negative men continued to have unprotected anal sex with their partner. These men described unprotected sex within the relationship as a means of redressing the imbalance in the relationship and loss of intimacy in sex. As such, the underlying motivations and details of the agreement may be quite different for serodiscordant couples.

Equality and Power

Early studies suggested that same-sex couples had a more egalitarian division of labor than heterosexual couples (Kurdek, 1993). However, there are other power dynamics to consider within relationships, which may be tied to HIV serostatus. According to social exchange theory (Emerson, 1981), relationship power is based on multiple factors, including dependence of one partner on the other, unequal possession of valued resources (e.g., economic, emotional), and potential alternatives to the current relationship. Relationship power is expressed through decision-making dominance, engaging in behaviors against a partner's wishes, or controlling a partner's actions (Emerson, 1972, 1981).

Only four studies in our systematic review examined power and relational equality and its relation to HIV-prevention or adherence. Men in monogamous relationships reported greater relational equality compared to men in open relationships or those who reported discrepant agreements (Hoff et al., 2009). Additionally, relational equality was associated with higher investment in sexual agreements (Neilands et al., 2010).

A qualitative study of nine gay male couples where one partner was living with HIV examined the meaning of reciprocity as it relates to HIV symptom management in the earlier years of the epidemic (Powell-Cope, 1995). The couples conceptualized symptom management as a form of mutual protection. Most partners strove for an equalitarian relationship, but HIV-positive men described the need to be independent in their self-care and HIV-negative partners worked to protect their partners from feeling dependent on them. Powell-Cope interpreted this behavior as a way to protect the ill partners' self-esteem by creating illusions of independence to offset losses to freedom. As the illness progressed, symptom management moved first into interdependent care where the HIV-negative partners monitored symptoms and then to dependent care where HIV-positive partners described "a loss of independence, humiliation, decreased self-esteem, anger, and depression as they had to relinquish responsibilities to partners" (Powell-Cope, 1996, p. 26). As the illness progressed, couples engaged in mutual protection using strategies to preserve the ill partners' feelings of independence and autonomy through managing the HIV-positive partner's health symptoms, diet, and medical care. This single study suggests that the stress surrounding an HIV diagnosis may create power imbalances within the relationship.

Dyadic Coping Among Couples with HIV

Only two studies within this review explicitly examined dyadic processes. These two studies were guided by interdependence theory, which focuses on social control tactics that aim to influence or regulate another person's behavior

(Lewis et al., 2006). It is assumed that both partners are motivated to try to change each other's health behaviors because each is affected by the other's illness or unhealthy habits (Butterfield & Lewis, 2002). Positive social control strategies, such as direct persuasion or influencing the enactment of desired behavior, have been hypothesized to be related to health-enhancing behaviors. Positive social control strategies contain elements of social support, for example by rewarding a desired behavior. In contrast, negative social control attempts (e.g., nagging or withdrawing affection) involve pressuring a partner into a desired health behavior change, for example, to reduce sexual risk; these tactics are often inefficient or counterproductive (Umberson, 1992). However, this may depend on the outcome (e.g., adherence vs. sexual risk) and one's orientation toward interdependence.

In a study of 60 same-sex couples (11 serodiscordant, 7 seroconcordant positive, 42 seroconconcordant negative), Lewis and colleagues (2006) found that many couples reported using positive social control tactics, such as discussions, presenting information, and asking questions, in relation to medication adherence. In contrast, the same couples described using negative social control tactics (nagging, setting rules and boundaries) when it came to HIV-related health compromising behaviors (e.g., bar hopping and sexual risk behavior). Interestingly, positive social control tactics were mentioned most frequently by those who scored highly on the interdependence measure.

In a qualitative interview study with 20 gay male couples (10 serodiscordant and 10 seroconcordant positive), Wrubel and colleagues (2010) found two opposing orientations towards partner support for medication adherence: *personal responsibility*, characterized by the belief that medication adherence should be the responsibility of the HIV-positive partner and *couple responsibility*, in which responsibility was shared. In a forced-choice question, one quarter of the couples (4 serodiscordant and 1 serodiscordant) described medication adherence as a personal responsibility and 12 couples (6 seroconcordant and 6 serodiscordant) described it as a couple responsibility. Among couples that endorsed personal responsibility, HIV-positive partners allowed themselves to be given emotional support but not practical assistance. Among those who endorsed a couple orientation, five couples described their relationship as one in which one partner was the "boss" or the "daddy-figure", and used positive social control tactics (regular reminding, problem solving, reinforcing) to increase medication adherence. In these couples power struggles were notably absent. More importantly, the dominant partner was not open to receiving support from their partner, and when it was provided it resulted in the dominant partner feeling annoyed and irritated, illustrating a very one-directional way of having the couple take responsibility. The other couples who endorsed a couples' or relational orientation were much more mutual in their provision of support and that mutuality involved different positive social control tactics from the "partner in control" couples (e.g., synchronizing schedules and dividing adherence responsibilities).

Homophobia and Heterosexism as Contextual Determinants of Dyadic Coping

Dyadic coping, along with other health behaviors, is affected by the larger sociocultural context (Revenson, 2003), including gender roles (Helgeson, 2011), ethnicity (Brondolo, Brady, Libby, & Pencille, 2011), and socioeconomic status (Ruiz, Steffen, & Prather, 2012). Sociocultural factors can have both direct and indirect (moderating) effects on health behaviors; for example, gender roles may influence norms about social support provision and expectations for interdependence among partners (Cross & Madson, 1997).

Structural forms of homophobia have defined as a societal level condition that constrains the opportunities, resources and health of gay men (Hatzenbuehler, 2009). Despite advances in LGBT rights, homophobia and heterosexism continue to produce stress in same-sex relationships, which may manifest itself as internalized stigma, concerns about sexual identity disclosure, and social validation. Only one study in our review explicitly examined experiences of heterosexism among same-sex male couples living with HIV and how they affected dyadic coping. Conducting a secondary analysis of interviews with nine couples (five serodiscordant, four seroconcordant positive), Powell-Cope (1998) found that most couples talked openly about experiences of homophobia in the context of caregiving. Couples described fears that being seen with their partner could lead to violence and assault. However, couples' utilized strategies to resist structural constraints imposed by heterosexism, including commitment ceremonies, and being open with family and friends about their couple status.

Although this study did not explicitly examine the link between homophobia and symptom management, these findings suggest that homophobia may affect couples' ability to draw on outside social support in their coping efforts. Although many couples, such as those described in Powell-Cope's small study, engaged in strategies to resist structural constraints, others may have a difficult time overcoming these barriers. This may produce additional strain on the relationship. In addition to the "regular" chronic stressors surrounding an illness diagnosis, same-sex male couples must negotiate social constraints that impinge on their ability to draw on social support resources in their dyadic coping (Fergus et al., 2005, 2009; Palmer & Bor, 2001; Wrubel et al., 2010). Similarly, same-sex couples may come to internalize negative messages about their identities and romantic affiliations, which may have an adverse impact on the quality of their relationships (Otis, Rostosky, Riggle, & Hmrin 2006). Thus, HIV prevention efforts that target more insidious influences, such as experiences of homophobia, may have long-term benefits for dyadic coping.

What Do We Need to Know to Construct a Theory of Dyadic Resilience?

The findings from this review provide minimal but preliminary evidence for the importance of incorporating relational variables and dyadic processes in behavioral HIV research. The studies examined a range of health outcomes among couples of

different serostatuses over a time period that has seen major medical advances in treating HIV disease. Nonetheless, the findings from this review suggest several important areas for understanding dyadic resilience among same sex couples coping with HIV disease, specifically, and chronic physical illness, more generally.

During the 20-year span that this review covers, researchers have focused primarily on social support processes when studying dyadic coping. (This is also true of research on heterosexual couples coping with illness; see Revenson & DeLongis, 2011). While community integration has historically been linked to optimal outcomes, integration into the gay community may have a detrimental impact on risk behavior for same-sex male couples living with HIV (Fergus et al., 2005, 2009). However, provisions of social support may buffer the association between community integration and sexual risk behavior (Fergus et al., 2009). Similar to other populations, social networks, which included support outside the relationship serve as a protective factor in terms of providing HIV-related support and general social support for same-sex male couples living with HIV (Beckerman, 2002; Fergus et al., 2009; Stumbo, Wrubel, & Johnson, 2011).

Relationship variables such as intimacy, commitment, trust, and power are essential to understanding HIV-prevention and adherence, perhaps as much as direct support transactions between members of the couple. Some aspects of relationships may undermine rational decision making in sexual encounters to promote risky sexual behavior, particularly among men in serodiscordant relationships (Nieto-Andrade, 2010; Remien et al., 1995). Shared perceptions of health threats (i.e., viral load suppression and biomedical strategies) may be important factors to examine alongside these relationship factors to fully capture sexual decision making processes. Similarly, sexual agreements are believed to arise out of concerns for sexual safety but this only appears to be the case for men in serodiscordant relationships where there is the very real possibility of HIV transmission within the dyad. As such, sexual agreements appear to foster closeness and connection and may have associations with other health behaviors beyond HIV transmission. However, nonmonogomous sexual agreements have the potential to confer HIV risk, particularly when they are not driven by HIV prevention beliefs or when breaks in those agreements are not openly disclosed and renegotiated to incorporate sexual safety. Power and equality within relationships also influence health behaviors yet few studies have examined how power and inequality impact dyadic processes, such as mutual decision making and its influence on risk behaviors.

The Importance of Context in Understanding Dyadic Resilience Among Couples with HIV Disease

Our literature review suggests some similarities between same-sex and opposite-sex couples in dyadic coping, but also as many differences. It also touches on some of the unique aspects of HIV/AIDS in comparison to other chronic illnesses. Although an examination of these similarities and differences is beyond the scope of this

chapter, it is important to emphasize the unique sociocultural context surrounding same-sex male couples living with HIV/AIDS that is often overlooked. For example, the couple's HIV serostatus is an important contextual variable as it reflects and shapes different health statuses, power differentials, and relationship functioning. Most studies include couples of different serostatuses (concordant positive, concordant negative, and discordant) but ignored these important distinctions or lacked sufficient statistical power to examine these differences, or more importantly, how they interact with other variables predicting dyadic coping and resilience. For the dyadic stressors of an HIV diagnosis, including fear of disease transmission, fear of loss of the partner, and issues of sexual safety to keep both partners healthy, may result in dyadic conflict for the serodiscordant couples (Remien et al., 1995). This conflict, in turn, may impact appraisals of relational quality for both partners, particularly the HIV-positive partners and may influence the couple's ability to maintain safer sex behaviors, treatment adherence and emotional intimacy. Simultaneously, men in seroconcordant relationships may choose particular partners as a risk reduction strategy (Eaton et al., 2009), to provide a sense of security that reduces potential disclosure stigma and fears of rejection (Golub, Tomassilli, & Parsons, 2009). Thus, future research is warranted to disentangle the impact of serostatus on dyadic coping among HIV/AIDS couples.

In our research review, we didn't address the larger sociocultural and political contexts of HIV (Ickovics, Thayaparan, & Ethier, 2000), which is another way that dyadic resilience among this population may be different than heterosexual and gay couples coping with other serious illnesses. Couples living with HIV may be affected by HIV-related stigma (Herek, 1990), which has been shown to create significant barriers to HIV testing, restrict the utilization of prevention services and the adoption of preventative behaviors including HIV medications, as well as produce excess stress on the individual living with HIV (Brooks et al., 2012). HIV-related stigma impacts the "relational, emotional, and physical health of HIV-affected couple members" (Talley & Bettencourt, 2010, p. 84).

Although no studies have explicitly examined the impact of HIV stigma on health outcomes, health behaviors, or dyadic coping among same-sex male couples living with HIV (Talley & Bettencourt, 2010), several studies in this review incorporated the ways in which same-sex male couples manage HIV stigma when examining sexual risk behavior and psychological adaptation, and give us some preliminary clues. Two early qualitative interview studies with same-sex male couples in serodiscordant relationships suggested that internalized HIV stigma may influence sexual functioning for the HIV-positive partner as a result of the guilt and shame that may accompany an HIV diagnosis (Powell-Cope, 1995; Remien et al., 1995). Thus, future research is warranted to examine how HIV stigma influences adaptive communal coping strategies between relationship partners and influences health outcomes.

Most of the studies in the review also overlooked the demographic context of the research, combining participants from different demographic categories (race/ethnicity, socioeconomic status) without openly discussing or examining the possible influence of these demographic categories on relationship factors, dyadic process,

or health outcomes. Given disparities in HIV prevalence, incidence rates, disease progression and AIDS mortality for HIV-positive Latino and African American gay, bisexual and other MSM (CDC, 2008; Diaz, Ayala, & Bein, 2004; Mays, Cochran, & Zamudio, 2004), it was surprising that not one article in this review considered ethnic group membership or socioeconomic status either in terms of relationship variables, dyadic processes or their relation to health outcomes. In fact, three articles did not even include information about the racial/ethnic composition of the sample. Of the studies that included information about race/ethnicity, the majority of samples comprised of largely White men (64–90 %) and even those that were more diverse did not account for race/ethnicity in their analyses. Similarly, only three included an indicator of socioeconomic status in their analyses. Yet these two variables are intricately braided within the context of living with HIV/AIDS and dyadic coping.

Much of the literature implicitly assumes that social discrimination affects HIV-behavior, but has not built this phenomenon into the studies. This is a timely lacuna as researchers have increasingly looked to the compounding effects of social discrimination to explain persistent disparities in health (Krieger, Rowley, Herman, Avery, & Phillips, 1993; Williams, Neighbors, & Jackson, 2003). The potentially damaging effect of racism and financial hardship on individual well-being has been well-documented (Diaz, Ayala, Bein, Henne, & Marin, 2001; Jones, 1992; Schuman, Steeh, & Bobo, 1985). Discrimination may give rise to social practices and policies that restrict employment, housing, education, and other health care opportunities, which can produce negative health outcomes in creating strain and tension within the relationship (Cutrona et al., 2003). Additionally, discrimination can produce negative emotional and stress responses for individuals (Gamarel, Reisner, Parsons, & Golub, 2012; Williams et al., 2003), and influence relationship dynamics (Otis et al., 2006).

In the HIV prevention literature, there have been studies that have examined the compounding effects of homophobia, racism and financial hardship on the sexual health of Black and Latino gay, bisexual and other MSM. Nonetheless, there are many unanswered questions about the ways in which the intersection of discrimination based on sexual identity, race/ethnicity and socioeconomic status impacts the lives of same-sex male couples living with the disease. For example, discrimination and the strategies that couples use to cope with and minimize exposure to discrimination may produce excessive strain on the relationship and give rise to conflict and/or social constraints on disclosure, which may influence health behavior support. Additionally, financial hardship may produce power imbalances within relationships thereby influencing relationship dynamics (i.e., investments in sexual agreements) and dyadic processes (i.e., negative social control tactics), which may lead to maladaptive health behaviors such as sexual risk behavior. Given the high rates of racial/ethnic disparities in HIV, more research is needed to understand the differential impact of racism, financial hardship, homophobia, and HIV stigma on men of color in same-sex relationships living with HIV.

Developing a Theoretical Framework of Dyadic Resilience

The questions guiding this review provide basic and valuable information on same-sex male couples living with HIV but also expose many unanswered questions. We see glimpses of Lepore and Revenson's (2006) tripartite model of resilience: recovery, resistance, and reconfiguration. However, one of the major obstacles to moving this research area forward is the lack of theoretical frameworks to guide research and intervention development. To expand the theoretical foundation of HIV prevention efforts among same-sex male couples living with HIV, we propose a social-relational model that integrates the existing findings on HIV prevention and adherence research on same-sex couples living with HIV with existing models of relationship science.

This social-relational framework is based in both interdependence theory (Rusbult & Buunk, 1993) and dyadic coping perspectives (Bodenmann, Meuwly, & Kayser, 2011; Lewis et al., 2006). Communal coping strategies arise out of a shared stressor that is communicated between the partners, shared desired outcomes, and more constructive communication (Bodenmann, 2005). Using dyadic statistical approaches, this framework can partition variables at the individual and couple-level levels of analysis to determine effects on health behaviors, relationship quality, and ultimately dyadic resilience. As described throughout this chapter, dyadic coping is part of a larger process that unfolds over time and includes reciprocal influences; that is, partners' dyadic coping strategies affect health outcomes, which in turn, shape dyadic resilience and ultimately future coping efforts (Lazarus, 1966).

This social-relational framework suggests that predisposing factors such as perceived threat of HIV transmission and/or disease progression, shared desired outcomes, and more constructive communication styles may influence couples' responses to HIV (Lewis et al., 2006). For example, HIV serodiscordant couples may have different conceptualizations of the threat of HIV on the relationship than seroconcordant couples (Brooks et al., 2012; Remien, Wagner, Carballo-Dieguez, & Dolezal, 1998; Wagner, Remien, Carballo-Diéguez, & Dolezal, 2002), yet no studies have examined shared threats and desired outcomes. Additionally, relationship characteristics such as intimacy, trust, commitment, equality and investment in sexual agreements and sociocultural factors such as discrimination and HIV stigma may influence the couple's ability to engage in optimal dyadic coping strategies, which in turn, may affect health behaviors and maintain the quality of the relationship.

At the heart of this social-relational framework is the premise that couples will engage in a transformation of motivation process whereby a partner moves from a perspective of self-interest to a *we*-focus in the face of a shared threat (Lewis et al., 2006). According to Lewis and colleagues (2006) "*transformation of motivation* is a key construct in interdependence theory that explains how interdependence arises when partners may accommodate to work together cooperatively, and why relationships are so influential on health outcomes" (p. 1373) As a result of this, the couple will engage in dyadic coping strategies to reduce the threat (Lewis et al.). For exam-

ple, research suggests that same-sex male couples living with HIV developed a "couple identity" to resist HIV stigma (Powell-Cope, 1995; Remien et al., 1995). Although no studies within this review examined this process in relation to health behaviors, transformation of motivation could influence partners to "cognitively and emotionally ascribe health events as meaningful for the relationship or their partner (Lewis et al., 2006, p. 1373). Thus, HIV prevention researchers must explicitly examine the significance that specific health behaviors have for relationship maintenance and satisfaction (Rusbult & Van Lange, 2003) as well as study how relationship variables affect dyadic resilience.

Elaborating upon Lewis and colleagues' (2006) formulation, this social-relational framework posits that relationship functioning promotes pro-relationship motivation and behavior (Yovetich & Rusbult, 1994). For example, commitment represents a long-term orientation to the relationship with intentions to persist in the face of stressors (Yovetich & Rusbult). Commitment has been shown to predict persistence in relationships, as well as relationship maintenance behaviors such as willingness to sacrifice and accommodative behavior (Weiselquist, Rusbult, Foster, & Agnew, 1999). The limited findings described earlier suggest that commitment is associated with sexual risk behavior, particularly among serodiscordant couples (Nieto-Andrade, 2010; Remien et al., 1995). However, shared perceived threat and desired outcomes may moderate these associations, such that couples who view HIV as a shared health threat and value reducing transmission risk may engage in dyadic coping strategies to eliminate the threat of HIV.

To capture the dyadic processes laid out in this framework, and take the steps to begin to define dyadic resilience in this context, the study of same-sex male couples living with HIV must move beyond a reliance on studies that are purely descriptive, cross-sectional, or limited to one or two variables. Qualitative studies provide us with an important means for identifying previously neglected variables and potential mechanisms for consideration in quantitative research (Fergus, 2011; Wrubel et al., 2008). However, complex quantitative designs are needed for testing complex theoretical frameworks. One important question that emerged from this review was *how* couples cope with HIV/AIDS over time, as the disease and relationship changes (Revenson, 2003). Prospective, longitudinal designs and daily experience sampling are a potential means of elucidating the dyadic mechanisms through which relationship factors and health status mutually influence each other (DeLongis, Capreol, Holtzman, O'Brien, & Campbell, 2004; Laurenceau & Bolger, 2005).

Our basic argument, which is by no means new, rests on the need to place a greater emphasis on relationship factors and dyadic mechanisms in order to understand health behaviors and dyadic resilience in the context of HIV. Researchers and clinicians have increasingly considered the need for more substantive research on how these processes influence health behaviors and outcomes (Burton et al., 2010; Karney et al., 2010). We would argue that there must be greater efforts to integrate contextual factors into the forefront of these investigations. There is a need to integrate and interpret complex, reciprocal associations between intra- and interpersonal

processes, and health-relevant behaviors, specifically in identifying some of the most complex relationships between discrimination and health for couples. If we want to understand and foster optimal health among same-sex male couples affected by HIV, we must make a commitment to changing the way we think about – and study – the mechanism through which dyadic coping plays a role in gay male couples' well-being if we want to understand dyadic resilience.

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Chapter 6
Relationships and the Neurobiology of Resilience

Brent J. Atkinson

As a couples therapist, my interest in neurobiology dates back to the early 1990s when studies emerged suggesting that automatic brain processes play a much larger role in organizing our lives than most of us realize. These studies caught my interest because of the automatic nature of many of the behaviors, judgments and interpretations that often emerged during non-productive interactions between distressed partners. Brain studies eventually helped me realize that even ordinary habits of thinking and reacting to life are largely organized by automatized, non-consciously-executed internal mechanisms.

The internal mechanisms involved in regulating stress and resilience are no exception. For example, many people have conditioned internal processes that keep them operating in task mode a large percentage of their lives. When in this mode, people are constantly in their heads, striving, planning, and often fretting about one thing after another. They have trouble relaxing and shifting into brain states that rejuvenate and restore inner balance. Hence, they become depleted and less resilient. Such people often try to relax, but they just can't do it because their brains *automatically* gravitate toward task mode. I began wondering, "Can the automatic brain processes that keep people stressed be changed?" In order to place the results of my inquiry in context, a general understanding of the current evidence regarding brain processes involved in resilience may be helpful.

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The Neurobiology of Resilience

While research on psychological and emotional factors that contribute to resilience has a long history (Curtis & Cicchetti, 2003), studies examining the neurobiology of resilience are fewer, appearing only more recently with the advent of brain imaging technologies (van der Werff, van den Berg, Pannekoek, Elzinga, & Van Der Wee, 2013). However, a growing number of neuroimaging studies conducted over the past 15 years suggest that there are specific brain areas and circuitries involved in resilient response to stress. Key brain areas include the hippocampus, amygdala, hypothalamus, insula, anterior cingulate cortex (ACC) and medial prefrontal cortex (mPFC) (Dedovic, D'Aguiar, & Pruessner, 2009). The majority of studies examining resilience processes in the brain have compared images of the brains of subjects who experienced traumatic events and subsequently developed symptoms of Post-Traumatic Stress Disorder (PTSD) with subjects who experienced traumatic events but did not develop PTSD symptoms. In these studies, traumatic events included experiences such as sexual abuse, severe injuries through accidents, and combat-related trauma. Subjects who did not develop PTSD symptoms in response to such events were considered more resilient. Key findings across studies can be summarized as follows[1]:

- *Larger hippocampus* (*HPC*) *volumes were found in more resilient subjects*.

Initial studies suggest the possibility that a smaller hippocampus may predispose trauma-exposed individuals to developing PTSD symptoms. The hippocampus is an important regulator of the hypothalamic-pituitary-adrenal axis, and a smaller hippocampus could diminish neuroendocrine regulation, resulting in a stronger emotional or hormonal stress response. Particularly notable is a twin study by Gilbertson et al. (2002) in which brain scans were performed on four groups of subjects (1) trauma-exposed subjects who developed PTSD symptoms, (2) the non-exposed twin siblings of subjects in group 1, (3) trauma-exposed subjects who did not develop PTSD symptoms and (4) non-exposed twin siblings of subjects in group 3. Smaller hippocampal volumes were found in both PTSD subjects (group 1) and their non-traumatized twin siblings (group 2) when compared to trauma-exposed subjects who did not develop PTSD symptoms (group 3) and their non-exposed twin siblings (group 4). Further, severity of PTSD symptoms in group 1 subjects was negatively correlated with not only their own hippocampal volumes, but also the hippocampal volumes of their non-exposed twin siblings (group 2). This suggests that lower hippocampal volume may be a familiar risk factor for developing PTSD in response to trauma.

- *More resilient subjects evidenced greater activation in the ventral medial prefrontal cortex* (*vmPFC*) *and rostral anterior cingulate cortex* (*rACC*), *and less activity in the amygdala* (*AMYG*) *and dorsal anterior cingulate cortex* (*dACC*) *when exposed to emotionally evocative stimuli*.

[1] The material in this section is gleaned from the comprehensive review of neuroimaging studies of resilience published by van der Werff et al. (2013).

The amygdala is involved in generating the fear response by activating the Hypothalamic-Pituitary-Adrenal axis that releases hormones involved in the stress response. The ventral medial prefrontal cortex is known to play an important role in regulating the amygdala and suppressing negative emotion, and is associated with lower cortisol levels (Hänsel & von Känel, 2008). The rostral area of the anterior cingulate cortex is involved in emotional regulation while the dorsal ACC is more relevant for non-emotional cognitive tasks (Etkin & Wager, 2007). Overall findings from neuroimaging studies of resilience suggest that the brains of resilient people are better equipped to tamp down negative emotion.

Plasticity in Resilience-Related Brain Areas

Are there conditions that facilitate or inhibit growth and activity in brain areas that enable resilience? Initial studies suggest that there are. In studies of rodents (Caldji, Diorio, & Meaney, 2003; Francis, Diorio, Liu, & Meaney, 1999; Liu, Diorio, Day, Francis, & Meaney, 2000; van Hasselt et al., 2012) and primates (Law et al., 2008; Parker & Maestripieri, 2011; Stevens, Leckman, Coplan, & Suomi, 2009), early stress has consistently been associated with impaired brain development. Specifically, chronic stress has been found to damage neurons and inhibit neurogenesis in the hippocampus and medial prefrontal cortex (McEwen, 2007). Stress has the opposite effect on the amygdala, causing dendritic growth accompanied by increased anxiety and aggression (Vyas, Mitra, Rao, & Chattarji, 2002).

Human studies yield results that are consistent with animal studies. In a study of women diagnosed with major depressive disorder (MDD), smaller hippocampal volumes were found in those who experienced chronic childhood maltreatment compared with those who had no history of maltreatment (Vythilingam et al., 2002). Early life stressors seem to modify normal hypothalamic-pituitary-adrenal axis activity, resulting in abnormal cortisol levels which, over extended periods of time, can damage various brain areas (Loman & Gunnar, 2010). A recent study compared the brains of 31 physically abused children with the brains of normally developing children. Compared with non-abused children, children who had been victims of physical abuse showed volume alterations in numerous areas throughout the brain (Hanson et al., 2010). Most notably, the abused children evidenced smaller orbitofrontal volumes. Further, the more severe the social stress reported by children and parents, the smaller the orbitofrontal volume was in the abused sample. Another study examined the brains of post-institutionalized children raised in impoverished orphanages in Eastern Europe and Asia (Tottenham et al., 2010). Children who were adopted from the orphanages at a later age were found to have significantly larger amygdalae than those who were adopted earlier on. Similar results were found in a sample of 10 year old children whose mothers had been severely depressed throughout their lives. Compared to children whose mothers were not depressed, children of chronically depressed mothers had significantly larger amygdala volumes (Lupien et al., 2011).

Supportive Relationships and the Neurobiology of Resilience

A number of studies in recent decades suggest that supportive relationships may contribute to resilience by reducing or protecting against the development of excessive allostatic load (Seeman, Singer, Ryff, Love, & Levy-Storms, 2002). Allostatic load refers to the wear and tear on the body that accumulates over time when an individual is exposed to chronic stress. Repeated exposure to real or perceived threats results in prolonged activation of the sympathetic–adrenal–medullary (SAM) and hypothalamic–pituitary–adrenal (HPA) axes, resulting in harmful levels of stress hormones which can damage the brain. This damage can lead to permanent dysregulation of the SAM and HPA axes, resulting in unregulated stress hormones (Juster, McEwen, & Lupien, 2010). Prolonged exposure to stress hormones can increase inflammation, raise blood pressure (and subsequently heart disease), damage muscle tissue, inhibit growth, and suppress the immune system (McEwen, 2000). Measurement of allostatic load includes combined indices of blood pressure and cardiovascular health, cholesterol, cortisol levels and epinephrine levels. In a study of subjects who were in their late 50s, T. E. Seeman et al. (2002) found that positive relationships were associated with lower allostatic load for both men and women. The same association was found in a sample of 765 subjects who were in their 70s, with the association being the stronger for men vs. women (Seeman et al., 2002). In a more recent study using data from the Social Environment and Biomarkers of Aging Study (SEBAS) in Taiwan, the presence of close friends and/or neighbors were found to be significantly related to lower allostatic load for both men and women aged 71 and older (Seeman et al., 2004). In younger subjects (aged 54–70), the presence vs. absence of a spouse was associated with lower allostatic load in men but not women (Seeman et al., 2004).

A key contributor to excessive allostatic load is thought to be an overproduction of the stress hormone cortisol. The positive associations between social support and physical health may be due in large part to the effect of positive relationships on cortisol levels (Heinrichs, Baumgartner, Kirschbaum, & Ehlert, 2003; Legros, Chiodera, & Geenen, 1988; Uvnas-Moberg & Petersson, 2005). The presence of close, supportive relationships have been associated with lower cortisol levels in adolescents (Byrd-Craven, Auer, Granger, & Massey, 2012), middle class mothers of 2-year old children (Adam & Gunnar, 2001), elderly widowed adults (Stafford, Gardner, Kumari, Kuh, & Ben-Shlomo, 2013), men and women aged 47–59 (Steptoe, Owen, Kunz-Ebrecht, & Brydon, 2004), healthy men (Heinrichs et al., 2003), college students (Lucas-Thompson, 2013; Maestripieri, Baran, Sapienza, & Zingales, 2010), 18–36 year olds from the UCLA community (Eisenberger, Taylor, Gable, Hilmert, & Lieberman, 2007), parents expecting their first child (Feinberg, Jones, Granger, & Bontempo, 2012), and relationship partners (Ditzen, Hoppmann, & Klumb, 2008; Kirschbaum, Klauer, Filipp, & Hellhammer, 1995; Meuwly et al., 2012; Papp, Pendry, Simon, & Adam, 2012; Rodriguez & Margolin, 2013). People who evidence attachment security have been found to have lower cortisol levels than those who evidence attachment anxiety (Brooks, Robles, & Schetter, 2011; Dewitte,

De Houwer, Goubert, & Buysse, 2010; Diamond, Hicks, & Otter-Henderson, 2008; Gunnar, Brodersen, Nachmias, Buss, & Rigatuso, 1996; Jaremka et al., 2013; Kidd, Hamer, & Steptoe, 2013; Oskis, Loveday, Hucklebridge, Thorn, & Clow, 2011; Powers, Pietromonaco, Gunlicks, & Sayer, 2006; Quirin, Pruessner, & Kuhl, 2008) or attachment avoidance (Brooks et al., 2011; Pierrehumbert, Torrisi, Ansermet, Borghini, & Halfon, 2012; Powers et al., 2006). Associations between attachment security and cortisol levels have been observed as early as infancy (Bergman, Sarkar, Glover, & O'Connor, 2010) and toddlerhood (Gunnar et al., 1996).

Overall, studies on relationship quality and cortisol levels suggest that close supportive relationships play an important role in boosting resilience.

Strengthening Individual and Couple Resilience

There is a growing body of evidence documenting interventions that induce structural changes in brain areas that promote resilience (McEwen & Gianaros, 2011). Studies suggest that physical exercise (Erickson et al., 2011; Pereira et al., 2007), cognitive therapy (Davidson & McEwen, 2012; de Lange et al., 2008), social service programs for older adults (Carlson et al., 2009) and mindfulness meditation (Hölzel, Lazar, et al., 2011) strengthen resilience processes in the brain.

Of particular relevance to the field of couple resilience is evidence regarding the benefits of mindfulness meditation. In addition to strengthening resilience-relevant brain areas, mindfulness training has been shown to enhance the functioning of couple relationships (Atkinson, 2013). Thus, mindfulness meditation may increase resilience via two avenues – one direct (through strengthening resilience-related brain areas) and the other indirect (through enhancing the quality of relationships). The remainder of this chapter is devoted to an examination of studies providing evidence for the impact of mindfulness training on individual and couple resilience.

Mindfulness Training and Resilience

Mindfulness involves a state of mind that is purposeful, non-reactive, non-judgmental, and attuned to the present moment, and has shown to be cultivated and strengthened through a process known as mindfulness training (Kabat-Zinn, 2013). The most well-researched form of mindfulness training is Mindfulness-Based Stress Reduction (MBSR), an 8-week program of systematic training in meditation as a self-regulatory approach to stress reduction and emotion management (Kabat-Zinn, 2013). However, many other mindfulness training courses exist across the country, including self-guided programs accompanied by audio-guided meditations (Salzberg, 2010; Williams & Penman, 2011). Three types of meditation are used most often in mindfulness training (Vago & Silbersweig, 2012). *Focused attention* meditation involves adopting the intention to keep one's focus of attention on a particular object

such as the breath, a visualized image, or sensations in the body. When the mind wanders, the practitioner avoids self-judgment and simply brings attention back to the chosen object of focus. *Open monitoring* meditation involves monitoring the content of one's experience from moment-to-moment, attending fully to whatever is present (sensations, thoughts, feelings, etc.) in an accepting, non-judgmental way. The third type of meditation involves focusing one's attention in a way that cultivates empathy and compassion for self and others. Known as *compassion* or *loving-kindness meditation*, it focuses on challenging one's unexamined thoughts and emotions toward other people, and developing feelings of empathy and love for people, beginning with oneself and extending, eventually, to those with whom one has conflicts and/or dislikes.

Mindfulness meditation has been shown to reduce anxiety and depression (Hofmann, Sawyer, Witt, & Oh, 2010), and has also been shown to influence biomarkers related to resilience (Kok, Waugh, & Fredrickson, 2013) – reducing blood pressure and cortisol levels (Carlson, Speca, Faris, & Patel, 2007; Matousek, Dobkin, & Pruessner, 2010), improving immune function (Carlson et al., 2007; Davidson et al., 2003), promoting resolution of psoriatic lesions in patients with psoriasis (Kabat-Zinn et al., 1998) and increasing telomerase activity (Jacobs et al., 2011). People trained in mindfulness meditation show less reflexive emotional interference and physiological reactivity when completing tasks, decreased negative mood states, faster decrease in skin conductance response after aversive stimuli, less startle response in reaction to aversive stimuli, and less distractive and ruminative thoughts and behaviors. Mindfulness practices have been shown to increase parasympathetic tone and decrease sympathetic activity, resulting in decreased heart rates, blood pressure, cortisol levels, breathing rates, muscle tension, and lowered oxygen and carbon dioxide consumption (Hölzel, Lazar, et al., 2011).

Evidence from controlled studies suggests that mindfulness training achieves its resilience-related benefits through promoting growth and development in areas of the brain that are known to promote resilience (Dedovic et al., 2009; van der Werff et al., 2013). Across 17 different studies, meditators have been found to have increased volume, density and/or gyrification in resilience-relevant areas of the brain when compared to non-meditating controls (Atkinson, 2013). Dozens of additional studies have documented functional and connective changes within and between brain regions in response to mindfulness meditation (Cahn & Polich, 2006; Chiesa & Serretti, 2010; Hölzel, Lazar, et al., 2011; Rubia, 2009; Vago & Silbersweig, 2012). The medial prefrontal cortex and anterior cingulate cortex are among the most widely cited brain areas of gross morphological change during and in response to mindfulness meditation (Vago & Silbersweig, 2012). A number of studies have also found that mindfulness practice decreases amygdala activation (Brefczynski-Lewis, Lutz, Schaefer, Levinson, & Davidson, 2007; Creswell, Way, Eisenberger, & Lieberman, 2007; Desbordes et al., 2012; Goldin & Gross, 2010; Herwig, Kaffenberger, Jäncke, & Brühl, 2010; Hölzel et al., 2010). Further studies have found greater gray matter concentration in the hippocampus in meditators vs. non-meditators (Hölzel et al., 2008; Luders, Toga, Lepore, & Gaser, 2009). One study detected structural changes in the hippocampus within a period of 8 weeks in

participants that underwent mindfulness-based stress reduction (Hölzel, Carmody, et al., 2011). fMRI studies show that meditation involves activation of the hippocampus and medial PFC (Lazar et al., 2000; Lou et al., 1999; Newberg et al., 2001), suggesting that the function of these brain regions is enhanced through regular meditation.

In addition to impacting brain areas that are known to relevant to be resilience, studies suggest that mindfulness meditation also strengthens couple relationships. Numerous studies have found associations between mindfulness and relationship quality/satisfaction (Kozlowski, 2013). Mindfulness has been positively correlated with marital satisfaction, empathic concern, perspective taking (Wachs & Cordova, 2007), effective communication and adaptive response skills when faced with relational stress (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007), and greater consideration of one's partner's point of view (Burpee & Langer, 2005). Barnes et al. (2007) found that mindfulness may help to inoculate partners against relational stress, and numerous studies suggest that mindfulness training may increase empathy (Beddoe & Murphy, 2004; Birnie, Speca, & Carlson, 2010; Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Hutcherson, Seppala, & Gross, 2008; Krasner et al., 2009; Leiberg, Klimecki, & Singer, 2011). Mindfulness training has also been found to increase interpersonal cooperativeness (Haimerl & Valentine, 2001), decrease reactivity in relationships (Pruitt & McCollum, 2010), decrease interpersonal problems (Tloczynski & Tantriella, 1998), increase partners acceptance (Carson, Carson, Gil, & Baucom, 2004), and increase sexual satisfaction (Brotto, Basson, & Luria, 2008; Brotto & Heiman, 2007; Brotto, Seal, & Rellini, 2012; Carlson, Speca, Patel, & Goodey, 2004; Goldmeier, 2013; Lazaridou & Kalogianni, 2013; McCarthy & Wald, 2013; McCreary & Alderson, 2013; Rosenbaum, 2013; Sommers, 2013).

In my own clinical practice (Atkinson, 2013), I have observed that mindfulness promotes a variety of processes that boost couple resilience:

Stress Reduction. Stress takes a significant toll on relationships. Fifty-four percent of Americans report fighting with people close to them due to stress and 26 % report being alienated from a friend or family member because of stress (American Psychological Association 2014). One of the most widely cited findings about mindfulness training is that it reduces stress and anxiety. Mindfulness exercises interrupt the brain's tendency stay in the energy-depleting "task mode," and help it operate in the rejuvenating and restorative "experiencing mode" a greater percentage of the time. As a result, partners who engage in regular mindfulness exercises are less stressed, agitated, irritable and "trigger-happy" with their partners.

Attentiveness. People in ailing relationships can often be heard saying things to their partners like, "You never listen to me!" Partners who have trouble being attentive when their mates are talking are often well-intended, but simply unable to prevent their minds from wandering or being sidetracked by reactions they have to what their partners are saying. Through continuously exercising the ability to notice when the mind has wandered or become sidetracked, then

bringing attention back to the original focus, partners who practice mindfulness become more able to regulate attention, listen to their partners, and notice important details about their partners' lives.

Empathy. Neuroscientific studies suggest that empathy involves vicarious experiencing of another person's emotions. But you can't vicariously experience another person's emotion if you aren't in touch with your own. Greater sensitivity to one's own internal states is one of the most consistent benefits attained through mindfulness training. Mindfulness exercises strengthen the insula and anterior cingulate cortex – areas that mediate interoception (attunement to internal sensations and feelings). As partners engage in mindfulness training come to experience their own emotions more vividly, they also become more able to tune into the emotions of their partners as well.

Response Flexibility. Mindfulness training increases the ability to notice the automatic "knee-jerk" tendencies of the brain, and this ability helps partners become more able to avoid reflexively following such tendencies. Partners become more able to avoid "buying into" their first impressions of their partners' motives, and they become more able to resist urges to interrupt their partners before they are finished speaking.

Mood Regulation. As partners progress in mindfulness training, they become more able to avoid unproductive rumination that perpetuates distress, and more able to engage parasympathetic processes that result in physiological soothing. Consequently, they operate with less desperation and intensity when upsets occur in their relationships.

Through boosting each of the above processes, mindfulness training increases both individual and couple resilience. Given the accumulating evidence regarding this dual-impact action, mindfulness training may be the most potent resilience-building practice identified in the scientific literature.

Conclusion

The studies reviewed in this chapter suggest that there are specific brain processes involved in generating resilience which include the hypothalamus, medial prefrontal cortex, anterior cingulate cortex, the hippocampal-pituitary-adrenal axis and the amygdala. Damage or malfunctioning in these regions can produce dysregulation of stress hormones which contribute to excessive allostatic load over time, resulting in a variety of cardiovascular and immune system problems. Close, supportive relationships may reduce allostatic load in part by reducing cortisol levels. Among interventions that facilitate resilience processes in the brain, mindfulness meditation holds particular promise due to its dual avenues of influence. Studies suggest that mindfulness strengthens neural processes that promote resilience and indirectly facilitates resilience through strengthening relationships.

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Part III
Investigations into Facets of Couple Resilience

Chapter 7
Mutuality and the Marital Engagement – Type of Union Scale [ME (To US)]: Empirical Support for a Clinical Instrument in Couples Therapy

Jefferson A. Singer, Beata Labunko, Nicole Alea, and Jenna L. Baddeley

The field of marriage and couples therapy is less than 50 years old (Gurman & Fraenkel, 2002), and is still wrestling with how to develop an applied science that can take the knowledge gained from research on relationships and convert it into effective interventions for treatment. Traditional social psychology tended to look at relationship variables, including love and attraction as intra-individual variables (e.g., Hatfield & Rapson, 1987; Hazan & Shaver, 1987; Hendrick & Hendrick, 1986; Meyer & Pepper, 1977; Sternberg, 1987). More recently, social psychologists have begun to consider more relational and interdependent variables to explain intimacy and close relationships. Several researchers have offered a social cognitive perspective on close relationships highlighting such variables as cognitive interdependence (Agnew, Van Lange, Rusbult, & Langston, 1998), relationship awareness (Acitelli, 1988, 1993), inclusion of other in the self (Aron & Aron, 1986), transactive memory (Wegner, Erber, & Raymond, 1991), communal strength (Mills, Clark, Ford, & Johnson, 2004), and the relational self (Andersen & Chen, 2002).

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In general and in agreement with this trend in close relationship research, clinical researchers and therapists conceptualize the couple's relationship as not merely the conjunction of two individual dispositions, but as a dynamic third that belongs within neither individual person, but exists as a third entity, the "we," which represents an integration of two separate individuals (Ogden, 2004). Therefore, much of the work of couples therapy is focused on helping individuals to acknowledge the existence of this "third presence in the room" in order to learn how to respect and nurture a couple's mutuality. From a clinical research perspective, the ability to measure a couple's attention to "we-ness" provides a potential yardstick to assess their capacity for resilience and perseverance in the face of conflict.

We define mutuality or "we-ness" as an understanding within the partners that they exist within a larger entity that transcends either of their individual selves, and entails feelings, cognitions, and behaviors that seek to promote the welfare and best interests of the relationship while maintaining a simultaneous awareness of each partner's individual concerns. However, it is noteworthy that "we-ness" does not entail doing everything together. Although it may appear that "we-ness" requires constant companionship or continual agreement between the partners, this is not actually the case. It is completely possible that two partners may find that the best way to sustain relationship mutuality is to allow a great deal of individual interests and separate activities. Feeney (2007) highlighted this phenomenon as a "paradox in close relationships where accepting dependence promotes independence" (p. 268). Therefore, the goal of mutuality is not uniformity but rather a coordination of concern for partnership choices that will enhance the commitment to and fulfillment drawn from the relationship. The crucial aspect of mutuality is a shift of mindset, in which both partners acknowledge the primacy of their relationship over individual and self-serving choices.

In this chapter we provide some initial psychometric support for a self-report measure of relationship mutuality – the Marital Engagement-Type of Union Scale [ME (To US); Singer & Labunko Messier, 2005] that we have developed and used in couples therapy. Through the operationalization, measurement, and assessment of mutuality or "we-ness," we have the potential to make a valuable addition to both clinical work with couples and close relationship research.

Mutuality in Couples

Sarnoff and Sarnoff (1989) pointed out that partners conjointly create everything in their relationship, and "they start to perceive themselves as a collective entity – as a "we." They then maintain that perception of their "we-ness" along with their self-images as separate individuals" (p. 28). This shared conception of "we-ness" leads to a significant shift in thinking about and perceiving the relationship. Considering the relationship as a mutually influenced and created concept empowers the members of the couple by providing them with the responsibility and motivation to work jointly on the relationship. Josselson (1992) noted that mutuality can be

understood as joining in and being in communion with another person that "occurs in the space between people, as a product of both of them, with each individual contributing to, participating in, and taking from it" (p. 148). This mutuality mindset becomes a cornerstone of resilience, providing the couple with a "true north" that is their compass of certainty in periods of frustration and increased stress. By returning repeatedly to their mutual commitment to the importance of the relationship, they can find the reassurance and forbearance that are critical in withstanding inevitable challenges and conflicts.

Sharpe (2000) offered an insightful, developmental approach to understanding mutuality in romantic relationships. She described mutuality as a result of "merging" that consists of several steps, which occur and often overlap in the lifetime of a relationship. With the progression of the relationship, the partners start to recognize differences that exist between them and try to incorporate them into their existing concept of relationship. Additionally, both partners search for "his or her own comfort level and balance between time together and time apart" (p. 118). As merging progresses, partners are able to cultivate their existing commonalities and differences, as well as develop multiple ways of staying connected. In truly mutual couples, both partners respect and validate each other's views, work together to accomplish common goals, and resolve their differences through compromise. Moreover, a critical achievement of mutuality is the internalization of the loving relationship.

Gottman and Silver's research (1999) confirmed the significance of this internalization in contributing to satisfaction with a relationship. Gottman observed that the couples who were able to generate recollections associated with closeness and original passion had a higher likelihood of coping with their problems and staying together than those who could not remember these memories. They also observed that distortion of happy memories from the beginning of a relationship could be an important sign of marital problems. Social and clinical psychology, over the past two decades, has been gathering evidence for the importance of shared memories about important relationship events (Singer, 2004).

Harvey and Omarzu (1997, 1999) developed a concept called "minding" that emphasizes the value of mutuality in achieving and maintaining relationship satisfaction and closeness. They defined minding as "a reciprocal knowing process that occurs nonstop throughout the history of the relationship and that involves a complex package of interrelated thoughts, feelings, and behaviors" (1999, p. 11). Harvey and Omarzu stressed that minding requires mutual self-disclosures, relationship-enhancing attributions, acceptance and respect, reciprocity in thoughts, feelings and behaviors, as well as continuity over time.

Sheras and Koch-Sheras (2006) introduced the Couple Power Therapy model, an approach in which partners learn how to transcend their individual identities and co-create a vision of their relationship that accentuates the couple as a single entity. The keystones of this model are the fundamental tasks that must be addressed by the couple entity, the "Four Cs" of couple power: commitment, cooperation, communication, and community. Commitment entails shared dedication to the entity of couple. Cooperation involves learning how to operate as a powerful team to meet common goals. Communication is based on using the power of language, speaking and listening

in order to convey a meaning that can be understood by both members of the couple. Community involves connection with another couple or a group of couples who mutually support each other's vision of successful relationships.

Skerrett's (2003) clinical work with couples dealing with chronic illness highlights the salience of promoting a sense of "we-ness" in couples therapy. Skerrett (2013) defined "we-ness" as a constant interaction among self, other, and relationship awareness. The first step of therapy focuses on helping couples to develop the "we" awareness through encouraging them to talk about the qualities of their relationship in the past and in the present. Subsequently, couples explore each partner's unique story of illness, and learn to appreciate their differences in order to support the "we." Finally, the third step involves teaching couples how to nourish and strengthen the "we." Partners are encouraged to jointly work on creating a couple's vision statement and build a plan that will assist them in achieving their common goals. Skerrett (1996) asserted that couple "we-ness" fosters individual growth of each partner, as well as relational resilience that serves as a protective resource for both partners.

Another recent clinical example of utilizing a sense of "we-ness" to increase marital satisfaction is the systemic-constructivist couple therapy model (SCCT), developed by Reid and colleagues (Reid, Dalton, Laderoute, Doell, & Nguyen 2006). According to Reid et al. (2006) "We-ness refers to the identity that each partner establishes in relationship to the other" (2006, p. 243). The therapy integrates individual qualities of each partner and interpersonal aspects of the relationship along with the social context of the couple to enhance partners' interpersonal processing. As a result, each partner starts to perceive and respond to the relationship in a new way and develops a greater sense of identity with the relationship. For the purpose of their research program, Reid and colleagues (2006) created the "we-ness" coding system utilized to code transcribed therapy sessions with couples that focuses on a sense of unity, partnership, internalized interdependence but also involves feelings of distinctiveness and autonomy.

A further advance in understanding mutuality has been offered by the feminist researchers at the Wellesley College Stone Center. By assuming the centrality of relationship in human life and development, the researchers criticized the traditional, individualistic model of therapy, which looks mostly at intrapsychic factors, and considers autonomy, separation, independence and boundary formation as a foundation of mature development (Jordan, 1991; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). What is now called the Relational-Cultural Model (originally the Connection Model as developed by Miller, 1976) grew out of this critique. It proposes that a central human necessity is the establishment of authentic and mutual connection in relationship. According to the model, mutual, growth-fostering relationships are characterized by positive qualities, or "five good things": increased sense of zest or energy, increased ability to act, clarity of self and other, greater sense of worth, and increased desire for connection. Mutuality, as the heart of the model, has been defined as "the bidirectional movement of feelings, thoughts, and activity between persons in relationship" (Genero, Miller, Surrey, & Baldwin, 1992, p. 36). The Relational-Cultural Model postulates that in addition to the individual

experience of both partners, there is a third aspect called the "we," which is greater than each or both of the members of a couple (Shem & Surrey, 1998).

Despite these promising conceptual developments in close relationship research, feminist theory and clinical work, there are very few clinical assessment instruments that might be used in couples therapy to determine a couple's orientation toward and practice of mutuality. The only self-report tools available to assess mutuality in close adult relationships are the Mutual Psychological Development Questionnaire (MPDQ; Genero, Miller, & Surrey, 1992) and the Couples Mutuality Questionnaire (CMQ; Reid et al., 2006). The MPDQ consists of 24 items that measure perceived mutuality. Respondents are asked to rate each item from both their own perspective and that of the significant other (e.g., "When we talk about things that matter to [other person], I am likely to be receptive."; "When we talk about things that matter to me, [other person] is likely to be receptive."). Ratings are made on a 6-point Likert scale, ranging from 1 (*never*) to 6 (*all the time*). The CMQ is a self-report measure that consist of 22 items that assess the degree to which each member of the couple perceives his or her interaction patterns as analogous with their partner's (e.g., "When it comes to disputes or fighting, we are equally likely to argue or fight fairly with the other."). The responses are made on 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Therefore, both the MPDQ and the CMQ seem to be primarily interested in the states of mind of individuals in a relationship, and do not capture the "we-ness" as enacted by both partners on a day to day basis, during the usual activities and decision making that comprise the relationship.

The Current Studies

This chapter presents the findings of two studies designed to validate a new measure of relationship mutuality, the Marital Engagement-Type of Union Scale [ME (To US); Singer & Labunko Messier, 2005], which could serve the needs of clinicians and couples researchers in assessing "we-ness." Moreover, the ME (To US) provides couple therapists with a practical tool to be used as an instructive intervention in their efforts to assist distressed couples in building better connection. This measure focuses on the interconnectedness of behaviors between the partners in a relationship and the mutual influence they have on each other. Therefore, the ME (To US) describes the way that mutuality translates into a couple's day-to-day behaviors. The Marital Engagement – Type of Union Scale [ME (To US); see Appendix 1] is a self-report measure that consists of ten questions that address mutuality in the domains of domestic chores, time management, financial decisions, child-rearing decisions, sexual intimacy, communication, future plans, and relationship with extended family (e.g., "We regularly (i.e., at least once a week) set aside time of 30 min or more that is exclusively for us as a couple to talk, share an activity, or simply hang out together."). The responses are made on a 7-point Likert scale, ranging from 1 (*not at all*) to 7 (*very much*). The childrearing question has two

versions – one for couples with children, and one for childless couples. Total scores range from 10 to 70, with higher scores revealing greater relationship mutuality.

In an effort to establish initial reliability and validity, Study 1 repeated the familiar and limited practice of treating the assessment of a couple's relationship at an individual unit of analysis. Even if individuals were being asked to evaluate mutuality, they were still only providing an answer indicative of one partner's perspective. In Study 2 involving married couples, the initial analyses continued this individual-based practice in order to replicate Study 1 results. However, we then employed dyadic analysis to capture the dynamic sense of "we-ness" that exists between the partners by employing a "mutuality discrepancy index." This index captured the "space between" each partner's individual ratings of mutuality. In both studies, the ME (To US) was examined in relationship to measures of marital satisfaction and each partner's self-reported physical health, since previous researchers have found linkages between marital quality and somatic complaints (Kiecolt-Glaser & Newton, 2001; Levenson, Carstensen, & Gottman, 1993). This previous research has highlighted how unhappiness and distress in marital relations takes a toll on the physical well-being of the partners. We hypothesized that discrepancies in mutuality might show a similar linkage to stress-related health concerns, such as poor sleep, stomach pain, and headaches.

Study 1

Study 1 assessed internal consistency, as well as convergent and predictive validity of the ME (To US). It investigated the extent to which relationship mutuality and positive and negative quality of marriage independently predicted the criterion variable of marital satisfaction. Finally, it examined the strength and direction of the relationship of participant and spousal health to marital satisfaction, quality of marriage, and relationship mutuality.

A total of 289 married participants (169 females, 99 males, 21 unknown) completed the online research survey. Participants ranged in age from 20 to 85 years, with a mean age of 47.19 years. Most were Caucasian (91 %, $n = 244$); 36 % had a 4-year degree; and 64 % were employed full-time. Marriages were 20.44 years long, on average ($SD = 12.81$), and ranged from 2 years to 61 years; 86 % of the sample reported having children.

Participants were primarily recruited from an adult psychology participant database managed by one of the authors, and through an e-mail sent to all faculty and staff members of a mid-sized university in the Southeastern United States. Respondents participated in the study through www.surveymonkey.com by completing the self-report questionnaires of marital satisfaction (Kansas Marital Satisfaction Scale; Schumm et al., 1986), quality of marriage (The Positive and Negative Quality in Marriage Scale; Fincham & Linfield, 1997), and relationship

mutuality (ME (To US); Singer & Labunko Messier, 2005). In addition, a question asked participants to rate subjective health status, as compared to others their age (Maddox, 1962), and a similar question asked participants to rate their spouse's subjective health status. Cronbach's α for the ME (To US) scale for males was .86 and for females was .91 demonstrating high internal consistency of the items.

Relationship mutuality correlated positively with marital satisfaction, r (295) = .72, positive quality of marriage, r (295) = .65, participant's health, r (267) = .19, and spousal health, r (267) = .32, $ps < .01$, and negatively with negative quality of marriage, r (295) = −.52, $p < .01$. Note, however, that the effects are larger for relations with satisfaction and quality variables compared to the health status of one's self or one's spouse. The first hierarchical regression analysis examined whether relationship mutuality, and positive and negative quality of marriage scores predicted marital satisfaction scores, while controlling for marriage length and participant's age. The control variables together accounted for 0.2 % of the variance in marital satisfaction score, $R^2 = .002$, $F(2, 264) = .26$, $p = .77$. Relationship mutuality, positive and negative quality of marriage scores together accounted for an additional 72.2 % of variance in marital satisfaction score, $R^2 = .72$, F (5, 261) = 136.84, $p < .0005$. Relationship mutuality predicted marital satisfaction (β = .31) along with positive quality of marriage (β = .38) and negative quality of marriage (β = −.32).

The next set of hierarchical regression analyses, computed separately for males and females, examined whether relationship mutuality, marital satisfaction, and positive and negative quality of marriage scores predicted participant health, while controlling for the participant's age. For males, the control variable accounted for 0.5 % of the variance in males' health, $R^2 = .005$, $F(1, 97) = .51$, $p = .48$. Relationship mutuality, marital satisfaction, positive and negative quality of marriage scores together accounted for additional 11.1 % of variance in males' health, $R^2 = .12$, F (5, 93) = 2.44, $p < .05$. Positive quality of marriage (β = .34) was the only significant predictor of males' health. For females, the control variable accounted for 1.1 % of the variance in females' health, $R^2 = .01$, F (1, 166) = 1.89, $p = .17$. Relationship mutuality, marital satisfaction, positive and negative quality of marriage scores together accounted for additional 4.4 % of variance in females' health, $R^2 = .05$, F (5, 162) = 1.9, $p < .10$. Relationship mutuality (β = .21) was the only predictor of females' health.

The results of Study 1 revealed that the ME (To US) is a reliable measure of relationship mutuality. Moreover, the results of correlational analyses revealed that the ME (To US) has convergent validity. Since the measure of relationship mutuality was highly correlated with measures of marital satisfaction, and positive and negative quality of marriage, there is definitional overlap among the measured constructs. Nevertheless, results of standard multiple regressions indicated that, after controlling for its shared variance, the ME (To US) displayed modest incremental validity in predicting relationship satisfaction. In addition, Study 1 indicated potential links between relationship mutuality and females' subjective health reports.

Study 2

Study 2 employed both individualistic and dyadic analyses to further validate the ME (To US). The first hypothesis pertained to within-partner effects and was based on each individual partner's score. It was expected that each partner's relationship mutuality would correlate positively with his or her own score on relationship satisfaction. The second set of hypotheses related to dyadic effects. It was expected that each partner's relationship mutuality would correlate positively with the spouse's score on relationship satisfaction. We also created a mutuality discrepancy index for each couple by summing the absolute differences between husband's and wife's responses to each ME (To US) item, divided by the number of items. It was predicted that a greater discrepancy between a husband's and wife's scores on relationship mutuality (as measured by the mutuality discrepancy index) would be associated with lower levels of each partner's scores on relationship mutuality, relationship satisfaction, as well as higher levels of health complaints. Additionally, it was expected that the discrepancy between husband's and wife's score on relationship mutuality would be a better predictor of each partner's health complaints than partners' separate ratings of relationship satisfaction. No specific hypotheses were generated, but we also examined whether the direction of the discrepancy (whether husbands or wives were higher in overall mutuality ratings) would affect the prediction of health complaints.

A total of 36 heterosexual married couples completed the research survey ($N=72$; 36 males, 36 females). The mean age of the sample was 43.5 years ($SD=14.32$) and ranged from 26 years to 82 years. Most were Caucasian (87.5 %, $n=63$); 39 % selected a high school diploma or GED as their highest achieved level of education, and 72 % were employed full-time. Marriages were 13.85 years long on average ($SD=15.14$), and ranged from 2 years to 59 years; 76 % of the sample reported having children.

Participants were community dwelling adults recruited in the Northeastern United States. Each couple received a take-home research package with two identical surveys, which were completed individually and separately, at a convenient place and time by both members of the couple. The package included the self-report measures of relationship mutuality (ME (To US); Singer & Labunko Messier, 2005) and relationship satisfaction (Relationship Assessment Scale; Hendrick, 1988). In addition, the modified version of Physical Health Questionnaire (PHQ; Schat, Kelloway, & Desmarais, 2005) was used to measure the participant's subjective somatic health complaints (e.g., gastrointestinal problems, headaches, sleep disturbances, respiratory illness). The respondents were also asked about the perceived somatic health complaints of their spouses. These ratings were made on a 7-point Likert scale, ranging from 1 (*not at all*) to 7 (*all of the time*). The ME (To US) was again reliable. Cronbach's α for the ME (To US) scale for 27 couples with children was .83 for men and .92 for women. Cronbach's α for nine childless couples was .86 for men and .76 for women.

Husbands' relationship mutuality scores were positively correlated with their own scores of relationship satisfaction, r (36) = .66, p < .01. Wives' relationship mutuality scores were positively correlated with their own scores of relationship satisfaction, r (36) = .70, p < .01, as well as negatively correlated with ratings of headache complaints, r (36) = −.38, p < .05.

Dyadic analyses revealed that husbands' and wives' relationship mutuality scores were positively correlated, r (36) = .57, p < .01. Moreover, wives' relationship mutuality scores were positively correlated with their husbands' scores of relationship satisfaction, r (36) = .58, p < .01.

In order to measure the correspondence between the sets of husband's and wife's scores of relationship mutuality, an index of discrepancy was computed for each dyad. Discrepancy index is a measure of dissimilarity, which "starts by assuming perfect similarity and then measures how dissimilar the two sets of items are" (Kenny, Kashy, & Cook, 2006, p. 322).

For husbands, larger discrepancies for relationship mutuality in the couple were associated with lower levels of relationship mutuality, r (36) = −.68, and relationship satisfaction, r (36) = −.48, ps < .01. For wives, larger discrepancy index scores were related to lower levels of relationship mutuality, r (36) = −.73, and relationship satisfaction, r (36) = −.50, as well as higher levels of overall health complaints, r (36) = .38, and sleep disturbance, r (36) = .35, ps < .01.

A set of hierarchical regression analyses, computed separately for husbands and wives, examined whether the mutuality discrepancy index and the relationship satisfaction scale predicted scores of overall health complaints, gastrointestinal problems, headaches, sleep disturbance, and respiratory infections, while controlling for participant's age. None of the regressions for husbands were significant. For wives, regression analysis predicting overall health complaints from the mutuality discrepancy index, and relationship satisfaction, controlling for wives' age was marginally significant, R^2 = .22, F (4, 31) = 2.20, p = .09. The mutuality discrepancy index (β = .38, p = .05) was the only variable that made a significant unique contribution to the regression, indicating that the greater discrepancy between wives' and husbands' scores on relationship mutuality, the higher level of wives' overall health complaints.

In order to examine whether the direction of the discrepancy in mutuality made a difference in prediction of satisfaction and health complaints, we divided the dyads into two groups, Husband Higher in Mutuality (n = 15) and Wife Higher in Mutuality (n = 19), based on whether a husband or wife in a dyad had a higher relationship mutuality score. Two couples, in which both members had the same relationship mutuality score, were excluded from remaining analyses. The pattern of zero-order correlations for the Husband Higher in Mutuality group revealed that the mutuality discrepancy index was positively correlated with marriage length (r (15) = .52), wives' overall health complaints score (r (15) = .58), wives' headaches score (r (15) = .57), wives' sleep disturbance score (r (15) = .57), and negatively correlated with wives' relationship satisfaction (r (15) = −.57), ps < .05. The pattern of zero-order correlations for the Wife Higher in Mutuality group

revealed that the mutuality discrepancy index was negatively correlated with husbands' relationship satisfaction score ($r\,(19) = -.51$, $p < .05$).

The set of hierarchical regression analyses, computed separately for the Husband Higher in Mutuality and Wife Higher in Mutuality groups, examined whether the mutuality discrepancy index, and wives' relationship satisfaction scores predicted scores of wives' overall health complaints, gastrointestinal problems, headaches, sleep disturbance, and respiratory infections, while controlling for wives' age. An analogous set of hierarchical regression analyses was computed for husbands' scores, but none of them were significant so we do not discuss them further. For the Husband Higher in Mutuality group, the regression analysis predicting wives' overall health complaints from the mutuality discrepancy index and wives' relationship satisfaction, controlling for wives' age, was marginally significant, $R^2 = .52$, $F\,(4, 10) = 2.72$, $p = .09$. The mutuality discrepancy index ($\beta = .78$, $p = .02$) was the only variable that made a significant unique contribution to the regression, indicating that for couples in which husbands rated relationship mutuality higher than their wives, the greater the discrepancy in their scores, the higher the level of the wives' overall health complaints.

Discussion

Across two studies, we were able to demonstrate the internal consistency of the Me (To US) and its significant relationships to marital satisfaction and physical well-being. We obtained these relationships, looking at correlates for individual partners and through dyadic analyses that allowed us to examine relationships within couples. In this regard, an innovation of Study 2 was the attempt to capture "we-ness" not simply as just an intra-individual variable but as a shared state within the couple. This shared "we-ness" was operationalized as the discrepancy (or lack of discrepancy) between the partners' perceptions of mutuality in their relationship, as measured by the ME (To US). The findings demonstrate that the mutuality discrepancy index is a novel approach to the investigation of "we-ness" that exists between partners in a close relationship. By quantifying the gap in their perceptions of mutuality, it provides a measure of the partners' relative convergence in their values and actions within the marriage. Furthermore, it is a better predictor of wives' self-reported health problems than their own self-reported relationship satisfaction. It could be speculated that one self-report measure would be a better predictor of another self-report measure, but instead it was the index of the "space between" both partners that was the best predictor of wives' health.

The above health findings are particularly intriguing with regard to gender differences. Although, the hypotheses in Study 2 did not assume gender differences in health prediction, a review of the past decade of studies on marriage and physical health outcomes suggests that there are differential costs and benefits of marriage for men's and women' health (Kiecolt-Glaser & Newton, 2001). Several researchers have suggested that protective effects of marriage are stronger for men than women

(e.g., Berkman & Breslow, 1983), with women enjoying better mental and physical health when they are in good marriages, and men benefiting from marriage, regardless of its quality (Hess & Soldo, 1985). Levenson et al. (1993) found that in satisfied marriages, husbands' and wives' self-reports of health were similar, while in dissatisfied marriages, wives reported more physical and mental health problems than their husbands. Study 2 confirms a stronger marriage-health linkage for women by revealing a gender disparity in the link between relationship mutuality and health complaints. In contrast to previous research, which mostly looked at each partner's report of their marital satisfaction, the present study examined the discrepancy in relationship mutuality, demonstrating that it is not just each partner's perception of low relationship satisfaction that might be detrimental to their health outcomes, but it is a quality of the couple's "we-ness" or shared vision that is linked to psychological and physical functioning.

In a related recent project, Baddeley, Singer, and Berry (2013) applied the mutuality emphasis of the ME (To US) to an expressive writing task (EW) performed by military couples adjusting to re-uniting after deployment. These researchers drew on ME (To US) scale items to develop mutuality and conflict coding systems for scoring the written accounts of active duty soldiers' reunions with their spouses. The coding schemes assessed mutuality and conflict across several domains of relationship functioning.

In a paired sample of 26 couples in which both partners completed the EW task, dyadic analyses revealed that higher levels of mutuality were associated with higher levels of marital satisfaction reported at the time of the EW task and then again at a 1-month follow-up. With regard to gender differences in the relationship of mutuality to physical health, the connection between mutuality and somatic complaints in women once again emerged. In looking at separate regressions for men and women predicting somatic complaints from mutuality and conflict, the women's mutuality scores were the only significant and strong predictor of follow-up somatic complaints.

Thus, this study and the two reported in this chapter detected a particular relationship between the strength of mutuality in couples and wives' somatic complaints. This finding fits strongly with our clinical observations, particularly when husbands report higher ME (To US) scores than their wives. Future research would benefit greatly from examining the possibility that wives are more likely to internalize and experience physical consequences of discrepant communication and misperceived mutuality in their relationships.

Since 2005, we have used the ME (To US) as a clinical tool in our couples therapy practice. Our standard practice is to have each member of the couple fill out the survey separately and to bring it back to session without having discussed their answers with their spouse. The therapist then reviews the items, totaling each partner's score and examining the discrepancy between each item. Results are then shared with the couple, highlighting both areas of strength and areas in which both partners indicate low mutuality. Of greatest interest to the couple and for the clinician are items in which the partners differ by more than two values on the rating score. Subsequent sessions pursue these areas of discrepancy and explore the

reasons behind them in an effort to clarify and, if possible, enhance the couple's efforts toward greater communication and connection in their relationship. Further elaboration of the clinical use of the ME (To US) is available in Singer and Skerrett (2014).

Two partners always bring a third party into the clinician's office. The couple's attention to and nurturance of this relational entity is critical to their success in treatment. The ME (To US) is a straightforward and practical tool for helping couples engage in a fruitful dialogue about areas in their relationship in which they are more and less successful in building mutuality, and a stronger sense of a powerful and flourishing "we."At the same time, the research presented in this chapter suggests that this instrument may also be valuable as a "translational" tool, offering a vehicle for capturing mutuality in more basic research and learning about the role of "we-ness" in maintaining marital satisfaction as well as the physical and emotional well-being of each partner.

Appendix 1

ME (To US)

Marital Engagement: Type of Union Scale

This scale should be filled out by each partner separately. Try to rate each item with your most honest and realistic answer. Do not answer how you wish the relationship could be, or how it has been at previous times, but how it has been within the **last 6 months.** Each item asks you to make a generalization, so do your best to think in overall terms from the last 6 months rather than about one or two specific instances. Please fill out all items and use the 1–7 rating scale provided below. Please circle the numerical rating that best applies to each item.

1=not at all, 4=somewhat, 7=very much.

(1) We discuss domestic chores and make a fair division of duties.

1 2 3 4 5 6 7

(2) We discuss and agree on major time commitments before making them (e.g., work schedules, business trips, social events, appointments, separate outings with friends, etc.).

1 2 3 4 5 6 7

(3) We openly discuss and agree on **all** financial resources and decisions (e.g. joint checking, big ticket purchases, shared mortgage, pooled investment, mutual beneficiaries, etc.).

1 2 3 4 5 6 7

**IF YOU HAVE CHILDREN PLEASE ANSWER QUESTION 4. IF YOU DO NOT HAVE CHILDREN PLEASE ANSWER QUESTION 4A.

(4) We discuss, reach agreement, and present a unified front about child-rearing decisions (e.g., discipline, privileges, academic goals, etc.).

1 2 3 4 5 6 7

(4A) We have discussed and are in agreement about our current stance toward having children.

1 2 3 4 5 6 7

(5) We communicate about and share a mutually satisfying sexual relationship.

1 2 3 4 5 6 7

(6) We have achieved a balance between pursuing recreational activities together and also giving each other space to pursue independent activities.

1 2 3 4 5 6 7

(7) We communicate about our deepest fears and vulnerabilities to each other.

1 2 3 4 5 6 7

(8) We regularly (i.e., at least once a week) set aside time of 30 min or more that is exclusively for us as a couple, to talk, share an activity, or simply hang out together.

1 2 3 4 5 6 7

(9) We discuss and continue to develop plans for how our life together might be over the next 10 years and beyond.

1 2 3 4 5 6 7

(10) We discuss and reach agreement about how to relate to and interact with extended family (e.g., in-laws, uncles, aunts, cousins, etc.).

1 2 3 4 5 6 7

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Chapter 8
Identification with the Relationship as Essential to Marital Resilience: Theory, Application, and Evidence

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Understanding the capacity for resilience in marital relationships is very important in light of the high divorce rate and the negative impact of marital stress on the physical and mental health of the partners as well as their children. Hahlweg, Baucom, Grawe-Gerber, and Snyder (2010) report that between 40 and 45 % of English, German, Swiss and Australian first marriages end in divorce and about 55 % of American marriages end in divorce. Furthermore, there are many studies indicating that the quality of the marriage impacts the physical health of the married partners. Kiecolt-Glaser and Newton (2001), for example, following an extensive review of 64 published articles, conclude that marital functioning is consequential to physical health. In addition, the U.S. National Center for Health Statistics through its Centers for Disease Control and Prevention, in conducting a national prevalence study, found that "…married adults were generally found to be healthier…" on a variety of health measures (Schoenborn, 2004). More recently, Miller, Holist, Olsen, and Law (2013), reporting on the results of a longitudinal study of 1,681 married individuals who were assessed at 8 time points over 20 years, demonstrated that initial higher levels of marital happiness were associated with better physical health later.

The repeated finding that marital satisfaction is associated with physical and mental health, although noteworthy, is insufficient insofar as these correlations among variables lack a more fundamental examination of not only what it is about a marriage that contributes to the covariance among these variables, but also what

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contributes to the capacity of marriages to maintain their very existence adaptively over a long time period. Achieving the goal of a scientifically substantiated discovery of what it is that makes marriage work fluently and well over a long time will contribute greatly to our understanding of marital resilience as well as that of the broader family system (Walsh, 2003).

The purpose of this chapter is to report on both the findings and theoretical insights of a research program that set out to understand better what is the *essence* of marriage, and from that information, to develop an intervention to improve couple functioning so as to foster marital longevity (Reid, Dalton, Laderoute, Doell, & Nguyen, 2006). This chapter contains four major sections: The first section begins with a definition of relationship resilience in light of the complex vicissitudes that marriages normally face; the second section describes the initial exploratory research undertaken to understand what the psychological essence of marriage is; the third section provides an overview of the empirical research that was done to evaluate the Systemic Constructivist Couple Therapy (SCCT) that was consequently developed; finally, the fourth section provides an overview of research and theory on the nature and processes of the self in order to explain the reorganization that takes place in each partner's sense of self so as to congruently accommodate their relationship identity. This theorizing explains the fundamental basis for enhancing the essence of the marriage in the service of promoting resilience.

The Resilience of Marriage

The resilience of a married couple refers to the process by which partners can jointly assimilate and accommodate to fluctuating circumstances over the lifespan of their marriage in a way that maintains and enhances the integrity of their marriage. Any two individuals living in a close committed relationship over decades are themselves changing biologically (Roberts, 2011) while at the same time accommodating to a wide variety of complex variables such as changes in employment careers, finances/economy, health, children, extended family and so forth. These variables combine in complex ways and affect the functioning of a couple's capacity to fulfill being committed to each other (Larson & Halford, 2011), to function as a unit, and to meet cultural values and expectations (Halford, 2011).

In order to discuss resilience and maintenance we need to know what a marriage is psychologically, what is its essence and what is it that the couple is maintaining. A dictionary definition of essence is "a basic or necessary constituent of a thing" that is both "intrinsic" or indigenous and "essential for the existence of that thing." Furthermore, that which is the essence is "contrasted with what is accidental, ephemeral, or superficial" (Random House Dictionary, 1968, p. 451). The essence is not a thing; rather the marital essence is a phenomenon the partners create and maintain. Thus what is at the essence of a marriage is far deeper than the partners merely following a script as if acting the part of being married. In some marriages, for example, the participants may have functioned for years in a comfortable yet

relatively superficial way as if each partner was following an implicit role script in an environment presenting them with few challenges. Yet that seemingly comfortable marriage may fracture when faced with major challenges for which the essence of the marriage was never well developed. It may well be that many of those marriages that are more resilient have benefitted by experiencing challenges through which the partners not only learned how to work together, but in working together, became increasingly motivated to keep the marriage intact for personal reasons (Neff & Broady, 2011). We will suggest later that part of that motivation is the investment each partner has at a very personal level to make the relationship survive. Thus, what is necessary in understanding resilience is determining what is the essence (i.e., that which is essential) of a marriage that allows the marriage to survive. Our research on marital functioning was done to ascertain what the essence may be for each couple.

Preliminary Exploratory Research on Marital Functioning

It takes a special kind of scientific investigation to understand how any one couple functions in ways to maintain the integrity of their marriage, and then to learn across couples what may be a common theme or core aspect that accounts for the ability of an otherwise diverse set of couples to function well over time. Indeed, a guiding intention underlying this research program was to avoid falling prey to the errors of positivism where one assumes what one is looking for is a 'thing' separate from the couple. Instead we assume that what is the essence of marital functioning is inevitably a *complex process* (not a thing) that a well-functioning couple is good at doing and being. We engaged distressed couples in examining themselves as a couple; an investigation shared with the clinical-research investigators. The following, therefore, summarizes some parameters and research processes along with some insights into marital relationships that may make it easier for the reader to appreciate how the initial exploratory research worked, and led to the development of Systemic-Constructive Couple Therapy (SCCT). SCCT, unlike other couple therapies, makes a point of guiding the couple towards realizing and reifying its own essence which in turn strengthens the integrity and likely resilience of their marriage.

Parameters for the Exploratory Research

Participatory Action Research (PAR) is a scientific method that avoids the errors of positivism by immersing the researchers within the phenomena rather than assuming they can stand outside and observe "it" (Argyris & Shon, 1989; Chevalier & Buckles, 2013). Our variation of PAR is the inclusion of the couple therapist or "clinical-researcher" to guide and work alongside the partners as they process themselves as a couple. An example would be the clinical-researchers guiding the couple

to experiment with a variety of techniques (some of which are later described) to see whether these enhance their deeper knowing of themselves as individuals and as a couple. This focus on deepening their self-knowing as a result of the PAR format has the partners continuously focusing not just on their relationship but also each other's thoughts, experiences, and feelings. As the partners engage in understanding and appreciating how their relationship is inherently a product of each other's perspectives, they are also experiencing a reciprocal validation of one another as they continue to exercise being an increasingly functional relationship.

There had been pilot work done by the senior author to set other parameters for doing this form of exploratory research. This preparatory pilot work had been conducted prior to adopting the PAR approach to engaging couples and included having the couples complete the Couples Self Awareness Questionnaire (Reid, 1995) which is a self-administered open-ended questionnaire designed to get each partner to begin thinking more and in different ways than they previously had about their relationship. Following such reflection, couples are guided to dialogue about their relationship so as to begin accessing and altering the couple's relational epistemology. Relational epistemology as used here is simply the assumption that each partner has an implicit knowing of their relationship that is inherent in how they respond to and function within the relationship with the other person. As partners purposefully explore what they know and experience in their relationship, they also become more conscious of their thoughts and accompanying actions and assumptions. That increased consciousness of their thoughts and feelings is a type of meta-cognitive awareness.

To illustrate how a metacognitive awareness is facilitated in SCCT, the couple is asked in the first session and then in the final session to take the position of a fly on the wall and describe what their relationship looks like from the outside in a more objective way. The quality of their answer would reflect their degree of knowing and to convey this consciously already begins to bring out a form of meta-cognitive awareness of themselves as a relationship. As the couple becomes more meta-cognitively aware of themselves and each other, and engages in this type of thinking and doing, each partner is drawn into a process of helping each other to enhance their marriage.

The PAR approach is based on two fundamental propositions as distilled by Susan Fiske (1992) in her review of the social cognition literature. These are that (1) humans normally function with only enough information to undertake their day-to-day activities, and (2) the principle that 'thinking is for doing' which means most active thinking is quite restricted as it is in the service of the moment. Thus SCCT focuses on (1) partners' current 'knowing' as that is inevitably their default when out and about in their daily life, and then (2) the gradual introduction of more relevant and novel information because as soon as that new information enters the picture, it automatically affects the partner's comprehension of him or herself within the relationship and his or her subsequent behavior. In SCCT, each partner is guided to realize how he or she automatically jumps to conclusions and reacts in ways that exacerbate relationship distress, rather than slowing down and listening to the other person's underlying meaning and feelings from that individual's perspective.

That increased self-awareness in the relationship, in turn, primes partners to become even more motivated to explore and share thoughts because doing so is perceived to be of value. In this example the novelty is a combination of both increased self-awareness of how they do not listen as well as they thought they had, and how previous failures to understand each other contributed to the negativity in the relationship.

Another well-studied phenomenon that has guided the development of SCCT is the dual processing theory of human cognition (Epstein, 1994). Dual processing refers to how normal thinking involves distinct experiential and rational processing modes, and it is the integration of these modes relative to the situational context that helps explain how individuals make meaning especially in relation to one's sense of self and others (Epstein, 1994). This dual processing scheme, similarly underlies the work of Daniel Kahneman (2011) as articulated in his book, *Thinking Fast and Slow*. Experiential processing is fast, imaginative, emotional and expansive; rational processing is much slower, analytical, logical and careful. Thus the induction of couples to participate in a process of deepening their knowledge of each other and their relationship entails facilitating their ability to effectively integrate *both* experiential and rational ways of knowing. What is crucial here is that we were working with the partners' natural need to be understood by the other and to tactfully assist them not just to think more broadly and deeply about their relationship, but to also be able to express this new, expanding awareness. The more knowledgeable or 'intelligent' the partners become about their relationship, the greater their capacity to override or replace past patterns with new ones that are inherently more rewarding for partners.

The Exploratory Research with a Succession of Referred Distressed Couples

This exploratory research began with literally one couple – two married partners and the clinical-researcher co-therapists studying the couple's relationship over the course of six, weekly 2-hour long sessions – with the goal simply being to improve the relationship. Then, we would apply the same approach with yet more couples, one couple at a time. In addition to helping the couple become aware of problematic patterns in the relationship, the goal was to reveal the 'knowing' that the partners were implicitly drawing on to understand themselves individually and as a couple. In the relationship science literature, these relational ways of thinking (Fletcher & Fitness, 1996; Hinde, 1997) have been described as a partner's relational mental model or schemata that are, in turn, accompanied by a relational epistemology or meta-cognition that is broader than such schemata. The relational epistemology entails a more pervasive, implicit knowing including assumptions about themselves as a relational unit. The partner's relational mental model (Bowlby, 1988) is like a cognitive schema of thought implicit in the partner's thinking of the other partner and the relationship they share, and such schemata are thought to be at the core of an individual's relationship functioning (Baldwin, 2005; Fletcher & Fitness, 1996).

The couple's relational epistemology or metacognition, on the other hand, is a broader more systemic or theoretical way of thinking beyond the specific cognitions one has about one's partner. Another way to describe relationship epistemology is the underlying relational paradigm that the partners are implicitly using. Scarvalone, Fox, and Safran (2010) propose that beyond relational schemas are higher level, "… generalized representations [that] contain the elaborated and implicit rules, beliefs, goals, action plans, and if – then strategies related to the self in interaction, and form part of what we consider procedural versus declarative knowledge (p. 364)." In line with this description, the couple's relational epistemology is their implicit way of 'knowing' and 'understanding' their relationship overall that inevitably accompanies their behaviors and feelings towards and about each other as individuals in a shared relationship.

One way to draw out the couple's relational epistemology is to ask the partners to think in terms of writing a play about their relationship with various scenes involving their relationship and to be able to direct the actors in the play to be like them. They would depict how this all works to adequately convey them as a relationship. Another way of drawing out this relational epistemology is to make a comment about how their relationship functions. The comment is articulated in a way to trigger or perturb their process of thinking about the relationship as a unit. An example would be a suggestion from the clinician researcher like "Well in this kind of situation you as a couple would do…[and specify an example]." The couple would usually instantaneously correct the clinician's comment and elaborate on how they would normally behave. Or, if they agree with the comment they would provide more details of how 'they' behave as a couple in that situation. What is of particular interest is how well the partner's agree on their answers; reflecting to what extent there is a common or shared relational epistemology. The effect of that kind of probing fits with the adage: "One does not know what the pattern or rules are until one violates or does not do them."

It takes work for a couple to think of themselves as a couple, especially to think of how they do things as a couple overall (Scarvalone et al., 2010) and yet they can present material in the form of examples and themes that only they can validate as accurate. The point is to facilitate that broader awareness on their part of how they see themselves functioning as a unit beyond merely focusing on the other partner or one's own personal plight in the relationship. Often the more egocentric thinking dominates and the partner's consequent attempts to communicate and gain each other's agreement, respect, etcetera, and this only leads to further disengagement and the commonly heard complaint that "we are stuck."

A good way to begin the process of shifting from an egocentric to a more systemic way of knowing the relationship is conveyed in the following example. In this example the partners (named Arthur and Jane) become emotionally engaged in arguing their personal views. The clinician-researcher instantaneously asks them to continue the debate but to only talk in the third person. Thus Arthur would say of him and her: "Arthur just felt misunderstood when Arthur heard Jane say that Arthur is not interested in Jane's feelings." Jane, in turn and avoiding the use of 'you' and 'me' terminology, replies: "But Jane was saying that Arthur never seems to want to

hear Jane sharing her feeling with Arthur." Talking in the third person, when emotionally intense with each other is sufficiently awkward as to force Jane and Arthur to slow down bringing awareness not just of their feelings and thoughts in the moment, but to be more mindful of each other as a relationship in real time. Arthur and Jane are increasingly likely to become more aware of their patterns and feelings interactively as they continue to maintain the deliberate conversation in such a novel way. When they lose control for the moment by sliding into their usual 'me'-'you' stance, the clinician-researcher asks them to re-enter and stay in the more 'reasonable' frame of reference to yet continue to communicate. This shifting in and out between their usual, emotionally loaded tone, to a frank yet mutually conscious discourse helps them to develop a kind of metacognition of themselves in the moment, which includes emotional regulation accompanying a metacognitive awareness.

During this exploratory research phase, it appeared as if what changed that relational epistemology was when either or both partners seemed to begin identifying how much he or she was intrinsically part of the relationship (i.e., increasing 'we-ness'). As one becomes more identified with the relationship, it is likely his or her relational epistemology or implicit metacognitive knowing of the relationship also changes and becomes more transparent. This, in turn, creates a better 'working alliance' for the couple and would account for the seemingly positive impact a good relationship has on the mind of each partner (Adams, Salter, Pickett, Kurtis, & Phillips, 2010).

The exploratory research program began with the senior author's arranging for distressed couples to be referred to his university lab for couple therapy. Each couple consented to participate in a number of audio-recorded sessions, knowing the purpose was for research on marital dynamics as well as receiving couple therapy. Each couple presented their issues at length and then was invited to join with the co-therapist clinical-researchers in collectively learning about their relationship. Each couple was told that we would follow three steps in our investigation of their relationship starting with (1) sharing what they know implicitly and explicitly about their marriage; followed by, (2) each partner's expanding on that knowing by learning from the other; and then having expanded that knowing, (3) they would with intention make a creative leap towards experimenting and doing novel things informed by what we (couple and therapists) were learning in order to improve their relationship. It is important to realize that each partner was witness to the processing and experiencing that the other partner was going through when expressing her or his self and the meanings they have. This is a form of collective, participatory learning (consistent with PAR) in which couples are drawn and guided by the therapists into a shared experience.

The audio recording of each session was reviewed prior to the next session, notes were taken, and the senior author began qualitatively analyzing the transcriptions of therapy recordings by applying a form of in-depth interview analysis to infer what the clients were possibly thinking as they spoke. It was from those detailed analyses that a coding scheme for relationship identity (i.e., we-ness) was developed and refined (Reid et al., 2006). What was being learned over the sessions with each

couple and then across the succession of couples studied longitudinally was then applied to subsequent couples undergoing the same form of therapeutic investigation. This intense, iterative combined therapeutic and research process led to the creation of a series of intervention techniques. These techniques were then tested and re-adjusted to deepen how each partner experienced him or her self and his or her partner – all in the interest of augmenting their identity with the relationship they shared.

Following this preliminary research phase, it was decided to undertake experimental research of couples receiving the same empirically grounded intervention protocol, later termed, Systemic-Constructivist Couple Therapy (SCCT) (Reid, Doell, Dalton, & Ahmad, 2008), with the focus being on enhancing each partner's identification with the relationship. SCCT is a multimodal intervention designed to be responsive to the indigenous dynamics of each couple while also being informed by a combination of principles from Social-Personality, Clinical Psychology and Experimental Psychological science. The reliance on these three different yet complementary areas of science is imperative as the intention of the intervention was to be better able to accommodate the myriad of factors – biological, individual differences, and socio-cultural – that impinge on marital function as explained earlier in this chapter.

Couple Identity or "We-ness"

The initially anecdotal data arising from the exploratory research were the words each couple was using. We deliberately recorded and transcribed the couples discourse during the first session and the final session because we were beginning to witness the couples' words were connoting an increasing sense of being a unit. These transcripts were formally chunked using a technique developed by Luborsky (1996) to identify when a partner was talking about the relationship (which we refer to as "relationship episodes"), and then coded for the degree to which the words reflected the speakers' sense of being part of a "we" (Reid et al., 2006). In our view, it is not so informative to simply count the number of plural pronouns such as "we", "us" and "our" terms. For us, the use of such words (i.e., 'we' or 'us') connotes that the speaker is meaning a kind of identification with the relationship that he or she has with his or her partner. Social cognition priming studies have demonstrated that a person's current level of thinking can be primed, without their awareness, to begin thinking differently than they had (Bargh, 2007). Thus we think that gradually each partner was beginning through the PAR approach, and indeed the eventual Systemic Constructivist Couple Therapy, to realize via social cognitive processes an identification of oneself with the relationship, and this identification became expressed in the thoughts and feelings which the partner's words conveyed.

We-ness should not be equated with identification with a group in a sociological way such as identifying with a larger group such as an army if one were a career soldier. The reason is that in the case of a dyad it takes both partners for the dyad to exist. One can dissociate from a larger group and the group can continue to exist which is a different dynamic from leaving a dyad. One can become estranged from extended family, and then possibly return or be invited back, without threatening the existence of the family. To leave one's marriage, however, means that the dyad no longer exists thereby depriving the other person of membership. The psychological estrangement of a divorce easily makes each partner much more sensitive, questioning, affected and in need of personal validation on a number of levels (Adams, 2011).

Alternatively, when each married partner is active in the dyad in a symbiotic way, the dyad is part of the life of its individuals. Symbiosis is defined as a close association that is mutually beneficial even when there are considerable differences (Random House, 1968); indeed there needs to be differences to have symbiosis. It is false, therefore, to equate "we-ness" with sameness, or just companionship. "We-ness" is a state of mind that also upholds and values the differences between the two partners as "we-ness," being a state of symbiosis, requires differences to make the relationship viable. Thus, when each partner experiences the marriage as an active extension of one's self, it invites an active coordination with the other even if begrudgingly or in an 'agreeing to disagree' sense, and in turn, maintains the relationship.

There is no doubt that the quality and degree of "we-ness" will vary from one couple to another just like one person's personality differs from that of the other. Each couple inevitably finds its equilibrium. Often difficulties in a relationship stem from a disconnect between partners on the degree to which each partner feels they are thriving in the relationship; one may be OK with the relationship, while the other is not OK. There are likely many who desire a far more fulfilling relationship than they have and thus the quality of their "we-ness" will be less and therefore more measured (as in degrees of). The hardest couples for a therapist to work with are likely those couples where the partners have reached a point of emotional indifference; that is, no interest or desire or even negativity in relation to the other. When such apathy has taken hold, partners may drift apart almost unknowingly until one day they find they have little in common. In such situations, the sense of "we-ness" or identification with the relationship has evaporated – sometimes to the point that either partner may have found greater self-identification in another relationship.

Theoretically, another benefit of establishing a sense of "we-ness" in both partners is it helps generate a greater sense of acceptance of each other, of one's self and thus the relationship as a whole. This quality of relationship includes not only acceptance of each other's idiosyncrasies but also an attitude of accepting the marriage (Jacobson & Christensen, 1996) as an ongoing forward moving process that keeps the relationship open to what life brings them, and secure in the relationship they have.

The Central Role of Partners' Identity with the Marriage for Resilient Couple Functioning

Reid et al. (2006) published a monograph which provides in detail the findings of two studies done with distressed couples, with a 2 year follow-up of the clients in the second study. An assumption of this approach was that the problems presented by the distressed couple were a product of problems in the relationship. Thus the therapeutic objective becomes to facilitate changes in the relationship which, in turn, would either lead the couple to their own solutions, or to the organic dissolution of the problems that they had created. SCCT is 'enlightened' insofar as the partners by working together solve their own problems and, in that way, any therapeutic changes in their relationship would fit their own ways of construing, experiencing, and responding interpersonally; that is, equilibrating the essence of their relationship.

The SCCT approach was designed to impact each individual's intrapersonal meaning making dynamics unique to them as well as the interpersonal dynamics between the partners.

The *intrapersonal* dynamics are best conveyed by the following heuristic algorithm used to guide some aspects of the SCCT intervention. The algorithm is "Understanding = Experiential-Intuitive Processing & Rational Knowing" explained in Reid et al. (2008). This algorithm is based on the dual processing model described earlier. Each partner individually and via their interpersonal participation expands her/his understanding through both experiential-intuitive (Epstein, 2008) and rational (Kahneman, 2011) ways of relating to each other. These two ways of processing are a means of making sense of both one's self (in relation to the other) and the relationship. Thus both the "I" and the "me" and gradually the "we" sense of self was facilitated to become more consciously expressed. An example of how to achieve this outcome is an SCCT technique used to both experientially and rationally draw out what we call the "internalized other partner". The therapist would interview one of the partners and ask him/her to 'be' the other partner. The therapist informed from what was being learned from earlier sessions would ask open-ended questions that were pertinent to both the personalities and the intimate knowledge the partners shared. The wife, for example, would use her implicit knowledge of her husband to imaginatively enact his responses. The husband watches from a distance as his wife enacts him as an interviewee, and when the interview was completed both partners would discuss the experience for both of them. Then, the husband is interviewed being her and they subsequently share their experiences (Reid et al., 2006, 2008).

The *interpersonal* processes refer to the systemic interpersonal dynamics between partners that include patterns, habits, culture, and shared values. SCCT was developed to help therapists understand through probing and careful active interviewing any one couple's dynamics including their personalities and then using these dynamics to explore how to enhance the couple's relationship. Detailed explanations of how SCCT works are provided in Reid et al. (2006) and Reid et al. (2008).

We-ness was assessed in all studies by coding transcriptions of audio-recordings of the couple's spontaneous discourse in the first session and then in the final session. Reid et al. (2006) provide an explanation of how to code for degree of "we-ness" including an appended coding sheet to accompany instructions. High levels of inter-rater reliability using this coding protocol for "we-ness" have been demonstrated (r = 0.76 – 0.78) (Reid et al., 2006). What is coded is the degree to which their sense of themselves includes the partner in a reciprocal way. The partners in these studies also completed two measures of marital satisfaction, as well as measures of mutuality (Reid & McKim, 2013), and the Inclusion of Other in Self Scale which is a series of 7 increasingly overlapping self with other Venn diagrams from which participants select the one that reflects their relationship with their partner (Aron, Aron, Tudor, & Nelson, 1991).

Two studies were run with each meeting the criteria for a process-outcome correlational design (Reid et al., 2006). All studies were one arm pre-post design. There were 13 couples in Study 1 (mean years married 20.2), and 13 couples in Study 2 (mean years married 23.1). Each distressed couple was referred for couple therapy and they received six weekly sessions lasting 2 hours each with all sessions audio-recorded. It should be noted that couples were not screened to meet any apriori study criteria and thus represented a sample similar to that of private practice. Partners independently completed the self-report questionnaires at the first and final sessions.

The main results in both studies were the same. There was a significant pre-post therapy improvement in: marital satisfaction, "we-ness", mutuality, similarities, and inclusion of other-in-self as a result of the SCCT therapy. Furthermore, pre-post increases in "we-ness" were correlated with pre-post increases in relationship satisfaction, mutuality, similarities and other-in-self. Finally, the significant correlations of "we-ness" derived from coding the couple's automatic discourse in the final session were correlated to with relationship satisfaction (r = .90/.71), mutuality (r = .79/70), similarities (r = .41/.42) and closeness (r = .64/.71) also measured in the final session, in both studies respectively. These correlations were of such a high magnitude that extra investigations of the data were conducted. The finding that We-ness was highly correlated with relationship measures of mutuality, similarities and other-in-self, provided convergent validity for the "we-ness" coding being a measure of relationship identification.

Study 3, also reported in the Reid et al. (2006) monograph, was a follow-up of the study 2 couples, taken an average of 21.2 months later. The findings were (a) the level of relationship satisfaction, mutuality, similarities, and inclusion of other in self remained at the same level as they were at the end of the 6 week therapy session and (b) "we-ness" coded in the final session of therapy correlated with high magnitudes on how well the couples were doing nearly 2 years later on satisfaction ($r = .69$), mutuality ($r = .65$), and other-in-self ($r = .79$).

Reid, Dalton, and Doell (in preparation) completed yet another study with 14 couples and this time included a measure of empathic accuracy as well as a measure of interpersonal processing that was hypothesized as the change mechanism operating within the SCCT. Empathic accuracy was measured using a video-playback procedure

developed by Ickes (1997) for behaviorally measuring how well each partner could infer what the other partner was thinking and feeling during a discussion between them. This overall procedure is done as part of the first 2-h therapy session, and then near the end of the seventh and final 2-h session. These data are used to ascertain how accurately each partner was inferring the other partner's thoughts and feelings during each session. Interpersonal processing is a 20 item self-report measure of the degree to which the respondent thinks of their relationship from each other's perspective and integrates those perspectives. Scores on this measure significantly increased as a result of SCCT.

The overall results were the scores on we-ness, empathic accuracy and the self-report measures increased significantly as a result of the seven SCCT sessions. At the final session we-ness scores correlated at a high magnitude with all measures including empathic accuracy and interpersonal processing. What is important in the findings was that the preceding correlations were across three different modalities: (1) Coding of therapy discourse for we-ness; (2) behavioral guesses of the other's thoughts during actual interpersonal discussions for empathic accuracy; and (3) self-reports on items measuring thinking from each other's perspectives – and integrating these to form a comprehensive measure of interpersonal processing. The explanation for these cross modality correlations is that collectively these measures reflect the emergence of a greater identity with the relationship. Further all of these measures correlated with self-report of relationship satisfaction. The greater the identification with the relationship (i.e., higher we-ness scores) correlated with a better intuition as to how the partner was thinking and feeling in the video-taped interaction and these in turn correlated with higher scores on interpersonal processing (thinking of each other's perspectives reciprocally). These findings were recently replicated with a new sample of 14 South Asian couples who underwent SCCT (Ahmad & Reid, 2015).

In summary, the findings across five studies (including the one follow-up study) are consistent in showing that the empirically derived measure of identification with the relationship was strongly associated with measures of satisfaction with the marriage. Furthermore, the two studies using empathic accuracy both found identification with the relationship at the final session was associated with empathic accuracy. What the latter means is partners that were higher in their identification with the relationship were also demonstrating a greater degree of knowing what one's partner was thinking and feeling during a discussion on a topic considered important to the couple.

Marriage Is a Complex Bio-Psycho-Social System Centred on a Sense of Self

Individual differences such as gender are part and parcel to marriage and many of these differences contribute to the benefits and at times the difficulties in the relationship. The partners may differ in their temperaments, coping mechanisms,

personal interests and at times, to use the vernacular, each partner is seemingly wired differently in terms of how they think, act, feel and sleep. Furthermore, each partner brings to the marriage their preferences, habits and values acquired prior to marriage and many from their family of origin. These differences and how well they are integrated or work symbiotically ought to be included in our understanding of how a marriage functions and is maintained. Christensen (1998) discusses individual differences that impact the functioning of couples.

The explanation of how a higher-order system such as the marriage emerges from lower-order systems such as the bio-genetic and personality idiosyncrasies of each partner relies, in part, on what scientists call 'emergence.' Goldstein (1999) has defined emergence in behavioral terms as "the arising of novel and coherent structures, patterns and properties during the process of self-organization in complex systems" (p. 49). A translation of this definition of emergence to understanding marriage would be interpreting the novel and coherent structures, patterns and properties unique to the marriage as the emergent result of the expansion of the self-organization of each of the two individual personality systems respectively so they can function interactively as a marriage. A conventional example of emergence as a phenomenon is the formation of water (H_20) from combining oxygen and hydrogen. Another way of conveying the meaning of emergence is the expression from systems theory that the whole is greater than the sum of its parts. Thus water is more than the sum of hydrogen and oxygen. Similarly, a marriage is more than just the sum of two individuals in the marriage. Rather, the dynamics of the interaction of the two persons to form the marriage requires a re-organization of the two partner's sense of themselves respectively to encompass being an active part of the marriage. At the *core*, then, is the capacity of the two partners to truly identify in a very active way with the relationship they share. The relationship is its own emergent phenomena from that joint identification with the relationship.

Epigenetics is a special form of emergence bearing relevance for understanding marriage. It applies not only to how a marriage evolves from the two individuals making the marriage work, but also to how the marriage requires changes in the ways that each individual experiences her/his self, respectively. What is important to stress is the change for each individual is beyond what they were when functioning individually insofar as each is now assimilating and accommodating to being in a committed relationship with the other. That marriage is thus an emergent product. Epigenetic inheritance research has discovered that the human's environment and experiences can influence the expression of their genetic code in a reciprocal way (Harper, 2010). Thus, it is not just the genetics that explain many behaviors but rather it is the combination of those lower level (i.e., bio-genetic) predisposition levels in combination with the appropriate environmental context and/or symbiotic triggers. In a parallel way, the interpersonal and highly experiential environment of being married can expand the expression of the person's sense of her or his self. It is not uncommon for married partners and even their close relatives to recognize each married partner has qualitatively changed since they got married. A profound example of the role of environment in relation to genetics is recent research providing evidence that personality differences of otherwise genetically identical twins may be

emergent from the interplay of genetic inheritance with environmental experiences (Kaminsky et al., 2008). What is crucial in borrowing from epigenetics and classic systems theory for understanding marriage is to realize that the hierarchy works in reciprocal directions insofar that the partners not only impact the creation of the marriage but their membership in a marriage also impacts the partners at an individual level. It is not uncommon for the therapist conducting couple therapy and research to realize the resistance or seeming lack of capacity for distressed partners to be able to fundamentally assimilate/accommodate their self to the relationship with the other is often a core struggle underlying the couple's dynamics even when otherwise attracted to each other and wanting the marriage to work.

Thus, the marriage provides the ongoing environmental context within which each individual learns to experience his/her self in ways they have not likely experienced before. That requires changes on the part of the individual partners in order to fit within the marital relationship. It is important to note, however, that the individual propensity for entering into a marital union (or its equivalent) is usually already informed or primed by cultural and societal scripts about what to expect. Typically, the main source of such information is the partners' parents and their role as models for commitment. Multiple other influences are found in culture (Poulsen & Thomas, 2011). We have found working with South Asian couples, for example, that culture at both the ethnic and familial levels has a major impact on partners' expectations and beliefs prior to getting married (Ahmad & Reid, 2008, 2015). Nonetheless, it is the experience of being married that inevitably impacts the person's sense of him or herself and usually this experience is self-enhancing especially when the marriage is functioning well. The experience of marriage by both partners includes their individual differences, their mutual learning and the internalizations of each partner on how to be married. The marriage is indeed greater than the sum of the individual personalities or partners. In order for the marriage to work well and remain resilient it is necessary to create ways of not only accommodating the underlying personal differences but to use their differences jointly to bolster and reify the marriage as if it is its own entity. A well-functioning marriage is a positive dynamic where the individuals feel they benefit and thus want to make the marriage work. This personal motive *to want* to make the relationship work is explained later.

The application of this dynamic hierarchical model to a marriage is a way of being able to better comprehend how each marriage is indeed unique and emergent from the combination of several factors. Furthermore, this emergent or epigenetic hierarchical model provides the clinical-researcher with a more comprehensive means by which to understand how, through the multiple levels of the hierarchy, the impact at one level can permeate through other levels so as to create much unintentional dysfunction or vulnerability in the marriage. An example is when one of the partners becomes ill with cancer or other disease. The disease impacts not only the coping by the partner involved, but it will also in an almost ricocheting way impact the marriage (Bodenmann, 2010). Another example is an overnight affair by one member that can similarly have a ricocheting impact on each other and thus the marriage (Hertlein & Weeks, 2011). Normally when such events happen there are resources at the essence of the marriage that can be brought to bear on the rela-

tionship. Oftentimes such demonstrations of resilience entail a mutually self-supportive way of coexisting for partners that includes learning together. There is the saying that it is not the mistakes or transgressions that define who we are, but rather how we respond to these mistakes and transgression that define who we are. Thus it is highly important that the assistance provided by a professional is guided by a scientifically developed model and approach that takes into consideration both the complexity of how the marriage functions and also supports the essence of the marriage so as to bring forth the couple's own abilities to change in order to remain resilient (Bischof, 2011).

Each Partner's Sense of Self and Its Impact on Marital Essence

The purpose of this section is to explain in more depth how one's sense of self adopts an identification with the relationship in order to function better as a person. What motivates such identification is likely an underlying need in most humans, as social animals, to be connected with others. The human need for an intimate relationship with another likely drives the creation of the essence of a marriage. The combined clinical and scientific challenge is to understand how to enhance and support the essence of a marriage in the direction of greater resilience. We consider the essence of a marriage as a complex process of equilibration that not only allows the marriage to change as a unit, but also for each partner to change in order to accommodate to the impact of a myriad of other factors ranging from the biogenetic to the cultural-linguistic and environmental context. The marriage remains resilient as a function of its essence being maintained.

We now turn to the question: how does enhancing and maintaining the essence of a marriage work? The answer to this question has to do with each married partner expanding her or his sense of self to encompass the marital relationship as part of their identity (Aron, Aron & Smollan 1992). As described earlier, we consider this as an identification with the marriage, and when each partner identifies with the marriage, there is a dynamic equilibrating synergy created between them that is the essence of the marriage. When each partner experiences the relationship as part of her or him, each partner is thus motivated and invested in making the relationship work because the relationship is so personal. Thus each partner needs the other. The implication is that the partner's spouse becomes a crucial and valued part of the relationship because without the other's involvement the partner has no relationship with which to continue the identification and the accompanying sense of self she or he has as a married partner. The loss of one's partner is therefore almost like losing part of one's self. It is well known that the loss of a life partner from death or divorce is ranked near the top of common life stresses (Holmes & Rahe, 1967).

A potential dynamic that results from both partners achieving a strong sense of identification with the marriage is that the individual member is also better able to express his or her own uniqueness because of the intimate support from their partner to do so, and that in turn makes the marriage all the more resilient (Feeney, 2007;

Reid et al., 2008). It is important to emphasize that this form of identification is with the relationship and not with the partner because it is the dynamic juxtaposition of valued individual differences each partner brings to the marriage that makes the marriage greater than the sum of its parts, and as previously described, is necessary for a functional symbiosis.

The understanding of the human's sense of self and the associated identity processes has expanded greatly in the past 20 years and has become quite profound for explaining human behavior (Leary & Tangney, 2012; Morf & Mischel, 2012) including the role of the self in interpersonal contexts such as marriage (Chen, Boucher, & Tapias, 2006). How the sense of self works is key to our understanding how the identification with the marital relationship also works and thus can be convincingly used to explain how a marriage can remain resilient. The central thesis is that each human uses her sense of self as a means to navigate their world, to make sense of their world and to be situated in time, place and of course, personhood. Modern day understanding of the self-concept is also informed by advances on the working of the mind such as the combination of conscious and non-conscious (i.e., automatic) mental processes working together (Bargh, 2007; Baumeister, Masicampo, & Vohs, 2011; Frith & Frith, 2012; MacLennan, 2007). There is also evidence of the significant role of intuition in people's thinking (Epstein, 2008). Intuition entails a feeling of knowing but one cannot necessarily explain that knowing. This intuitive knowing often accompanies the individuals' quality of knowing who s/he is that is typically taken for granted (i.e., assumed). There is even some neuroscience research connecting one's sense of self to functioning at the neurological level (Beer, 2012; Lieberman, 2007). Siegel (2012) makes the case that "relationships and the brain interact to shape who we are" (sub title of his book) in his review of the literature on interpersonal neurobiology. Siegel describes the influence of relationships for individual development and outlines how this sense of knowing one's self requires feedback from interaction with others.

At the core of interpersonal psychological functioning within marriage is the robust and basic phenomenon that each partner feels they understand themselves at least to an appreciable degree. In other words, a person's sense of their selfhood is a given; it is part of their assumptive world (i.e., taken for granted). One's sense of self is so omnipresent in one's thinking it provides the bedrock for his or her worldview and meaning making (Kauffman, 2002). Furthermore, every person is responsive to feedback that allows them to adjust and thus maintain this self, as they relate to others. That notion also applies to each partner in a relationship.

It is helpful when comprehending the dynamics of a marriage to interpret a married partner's sense of her or his "I" as an experiential, emotional, highly quick, and intuitive knowing in the moment, whereas the "me" is the slower more rational, conceptual "self as known." It is crucial to realize that for both partners his and her sense of self respectively is omnipresent in how each married partner understands or experiences and reacts to one another. According to Morf and Mischel (2012) the "I" is a cognitive-affective motivated action system, more the doer and feeler and guided by visceral rather than rational cognition. The "me" is the partner's concept

of self and is what s/he believes is true to one's self and what comes to mind when s/he thinks of one's self. How one is treated by one's partner can instantaneously activate one or the other form of processing – one's *knowing* (i.e., the "I") or one's concept of self (i.e., the "me"). A partner's quickness to react to being invalidated, or insulted, or not heard is an example of both an individual's defensiveness of one's self and subsequent assertiveness to promote who they are including their beliefs and meanings so as to maintain their sense of self within the situation (Oyserman, Elmore, & Smith, 2012). In a well-functioning marriage where both partners identify with the relationship these reactions to each other are largely positive and proactive following their identity as wife and husband respectively and serve the ongoing validation of the relationship that they share. Thus, each partner's quickness to appreciate feedback that is self-validating contributes towards more mutual engagement in the interaction. Moreover, each partner's sense of self as being part of the shared relationship helps both navigate their marriage in a more mutually sensitive way; that dynamic, in turn, contributes to how automatically comfortable and effective partners feel within their marriage and a resilient relational essence.

Personal Identities as an Extension of One's Self Concept

A central way an individual uses their sense of self to navigate their worlds is to develop personal identities that are relevant to their being who they are in a variety of situations. These various identities are connected with both one's sense of self and one's concept of self in an amalgam of differing roles or situations in which he or she lives. Having these identities aligned with one's core sense of self allows the person to behave quite differently from one situation to another and yet retain a sense of self coherence. The more each partner in a relationship has an identity with the relationship they share the more they will have learned to work together in an interpersonally coherent way.

To have an identity is to internalize the role and characteristics, such as being a wife or husband, within one's concept of one's self and to operate accordingly (Baumeister & Vohs, 2012; Ryan & Deci, 2012). Such socially derived yet self-ascribed traits and roles are internalized into what theorists call a "self -system" (Morf & Mischel, 2012; Sullivan, 1953). Evidence of the self-system is the individual's own use of terms such as my 'ideal-self,' my 'caring self,' my being a 'good wife,' or use of phrases such as "there is a part of me that likes to compete" or "there is a part of me that likes to be alone at times." Each of these self-references reflect facets of the person's sense of self that the individual instinctively responds with when the environmental context primes that facet of one's self to appear.

Collectively these identities make up one's overall self-concept (Oyserman et al., 2012) and these identities inclusive of the internalized self-system are very useful and rather automatic in allowing the individual to adapt and function. So too is it important to have a well-grounded sense of self as an active part of the marriage.

Thus a president of a large company who also has a strong identity as the husband in his marriage will be less inclined to manage the marriage like he manages the company where he works. The boundaries are well instilled in his sense of his self. The point to stress here is that when partners identify with their marital relationship, the quality and complementary maintenance of that identification with the marriage on the part of both partners is the psychological process with which the marriage can adapt, grow, and be resilient. It is here where a husband and wife respectively being identified with the marital relationship can work so well and so quickly. As with any social system it is important to occasionally reaffirm the existence of the relationship. Thus, it is important to avoid partners unintentionally drifting apart due to conflicting careers or letting their children's diverse activities detract from the husband and wife having quality times together. A good maintenance strategy is for the couple to make sure their relationship is a priority because that same relationship inadvertently both instills and maintains each other's self and self-confidence which in turn helps them cope in everyday living.

Personal Identity as Motivational and Meaningful to Relationship Maintenance

The married partner having developed a facet of one's self-concept that is an identification with the marriage will increasingly operate and interact more fluidly with the marital relationship as Morf and Mischel (2012) contend, "The intrapersonal processes within the [married partner's] self-system are in continuous seamless interaction with the interpersonal relationships [i.e., the marriage] within which the self-system is contextualized (p. 37)." Furthermore, identity is motivational insofar as a person will automatically interpret situations that are currently active in their identities and will normally express identity congruent actions. Explanations for this prediction range from William James's observation that "thinking is for doing" in that what a person is thinking is usually consistent with what they subsequently do (Fiske, 1992) to cognitive dissonance theory that predicts humans will behave in ways that are consistent with what they are currently thinking and vice versa (Festinger, 1957). Thus, a married partner who identifies with the marriage will be motivated to behave in ways to uphold the relationship in order to be consistent with her/his self. That state of experiencing the relationship as part of one's self is not only self-validating, it is interpersonally rewarding, meaningful, and often consistent with the culture and society within which the marriage is situated. The occasional disagreements or even arguments in a marriage are often merely readjustments to the situation, particularly when these disagreements are coherent with the couple's relationship epistemology. Ruptures occur when either or both married partners' sense of self in the marriage is significantly challenged or not validated. The need for validation of one's relationship identity can motivate repair and also learning

from ruptures so that the existence of the marriage remains, and is even possibly enhanced, as the partners adapt to each other.

Implications for Understanding and Facilitating Couple Resilience

Karney and Bradbury (1995) provide the largest scholarly overview of theory, method and findings on the longitudinal course of marital quality and stability entailing over 200 independent variables. Christensen (1998), in reviewing their findings, commented on how daunting it is for clinicians to incorporate so many variables into their interventions. Karney and Bradbury (1995) proactively responded to this challenge by reducing these variables into a 'vulnerability–stress–adaptive' model of marriage to guide both research and presumably interventions; a model they also critique constructively. They use the model and their criticism to emphasize the need for better longitudinal theory to guide future research and presumably, therapeutic interventions in order for the research to enhance marital quality and longevity. Their model is composed of the following three broad classes of variables: (1) stressful events; (2) enduring vulnerabilities that the spouses bring to the marriage; and (3) adaptive processes the spouses use to adapt to the difficulties the couple may experience. These authors recommend that researchers create inclusive constructs that can be used as a "…means of contending with the diversity and complexity of marriage" (p. 27). They explain, "For example, one marriage may fail because the husband is impulsive, whereas another marriage might fail because the husband is neurotic. On one level, these are different phenomena because the traits examined are different. From the present perspective, however, these couples may be quite similar. In both marriages an enduring vulnerability may lead to increased stress and poorer adaptive processes" (p. 27).

We would like to suggest that building a more promising model of resilient couple functioning ought to include components that mirror the complex bio-psycho-social systems embedded within the marital dyad as discussed in this chapter. Many of the variables Karney and Bradbury (1995) identify from the research can be classified according to the bio-psycho-social substrates as a dyadic systemic emergent model. This systemic emergent model is more fluid and maps onto the dynamics of marriages because of its emphasis on process that goes beyond reliance on only predictor variables. The research findings on these dynamics are largely indigenous to the functioning of actual marriages in real time, albeit in professional couple therapy sessions. In order to deal with the complexity and dynamic multivariate determination of marriage, marriage in the proposed model of relationship resilience is described as an emergent epigenetic phenomenon based on the dynamic input from two interactive humans or self-systems. The marriage, in turn, is situated within a

hierarchy of systems ranging from bio-genetic to cultural-linguistic systems. Furthermore, the very essence of any marriage is the complex equilibrating process that is necessary for the integrity and existence of the marriage as a functioning unit. That equilibrating process is likely similar to the adaptive processes Karney and Bradbury (1995) identify.

From a psychological perspective, the ultimate unit of analysis is each partner's integrated intrapersonal and interpersonal ways of functioning that are inclusive of how each partner's mind works and adapts – experientially and cognitively. These experiential and cognitive processes include social-learning and social-cultural parameters as well as the overall mental and physical health of the individuals. How each partner functions as part of the marriage requires their being active members of the marriage and we suggest it is the quality of the identification each partner gains in the marriage that is at the core of the quality and longevity of the marriage. Thus the impact of hundreds of variables on the quality and longevity of the marriage is mediated by the partners and how they function at a dyadic level. A model that is based on these concepts and approach will not only help advance both our understanding of marital resilience and how best to assist couples seeking to enhance their marriage, but also better integrate ongoing research on marital dynamics.

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Chapter 9
"We-ness" in Relationship-Defining Memories and Marital Satisfaction

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> The single largest negative event in my relationship occurred… about a year after the birth of our first child. My husband and I were adjusting to life with a newborn and I had taken time off of work to be a stay-at-home-mom. I was hormonal and no longer had the familiarity of going to work and being at the office with my husband every day. Prior to the baby, my husband and I worked as a team at the office and spent a lot of time together. After the baby came, I was home, he was at work and we both resented each other for not being available. Resentment grew into negative feelings which pushed us further away from each other emotionally until it all unravelled… I found myself in the fetal position on my bathroom floor, crying, on the phone with him and talking about divorce… we both knew we didn't want to go through a divorce. He agreed to counseling and after many months, began repairing our relationship. That event has made our marriage stronger today.

The above narrative excerpt is from a 52 year-old woman who had been married to her husband for 18 years. The event occurred more than 15 years before we asked her to take part in a research study in which participants shared both positive and negative *relationship-defining memories* (Alea & Vick, 2010). The above was her negative memory. Relationship-defining memories are recollections about specific, significant events that occur during the course of an interpersonal relationship, and are vividly and emotionally remembered. The emotion and imagery comes across clearly in this woman's narrative: there is a very sad woman curled up on the bathroom floor. Relationship-defining memories are usually thought about often, have been shared with others, and remain salient for the person over time. It is almost a certainty that other negative events have happened in this woman's marriage, but

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this one, from 15 years ago, is the event she chose to recall. These memories are a reflection of the relationship, represent an enduring theme, and can be linked to other memories that have occurred. These types of memories are unique in that they are central in the life of the relationship, and stand out from the myriad of other potential memories that a person may have over the course of, for example, 18-years of marriage.

In definition then, relationship-defining memories are similar to Singer and colleagues' self-defining memories (e.g., Blagov & Singer, 2004; Moffitt & Singer, 1994; Singer, 2004a; Singer & Salovey, 1993) which reflect a person's life goals, personal concerns, dispositional traits, and distresses, and serve as an anchor for a person's sense of coherence over time (Conway, Singer, & Tagini, 2004). Relationship-defining memories serve the same function not for the individual (McLean & Thorne, 2003), but for the unit – the "we." Acknowledging the "we-ness" or interdependence, connection, and mutual influence on one another in a marriage is a property of marital resiliency (Skerrett, 2003). Relationship-defining memories should reflect this "we-ness", if it exists in the marriage, and perhaps do so differently for positive compared to negative events. Does a couple feel a sense of unity, or togetherness only during the positive times, or might it be even more important to experience "we-ness" during the bad times (e.g., Skerrett, 2003)? To clarify, we are not suggesting that there is not an individual in a relationship, or an "I." In fact, the healthiest relationships may maintain a balance between inter- and independence that best suits the rhythms and relational needs of each partner (e.g., Aron & Aron, 1997; Feeney, 2007; Reid, Dalton, Laderoute, Doell, & Nguyen, 2006). Thus, the goal of the study presented in this chapter is to examine differences in the extent to which married individuals express "we-ness", compared to "I-ness", in both positive and negative relationship-defining memories, to assess the relation of both states of mind to marital satisfaction, and to consider potential clinical implications.

Relationship-Defining Memories and Marital Satisfaction

The initial research on relationship-defining memories by Alea and Vick (2010) focused on what were referred to as "first encounter memories" or those moments in a relationship when a person has the first inkling of enduring love and relationship potential. These first relationship memories are the anchor for a couple's story and reflect the current aspirations and satisfaction in a marriage, and hopes about the future (Belove, 1980). In their study, Alea and Vick (2010), asked married men and women from young adulthood to old age to report their marital satisfaction, and then to write about their first encounter memory. Participants then reported on how vivid the memory was, the emotional quality of the memory, and how often the memory was rehearsed, or thought about and shared with others. They found that remembering the first moments of a relationship with vividness and heightened emotion predicted higher levels of current marital satisfaction.

In a follow up study, Alea and colleagues (2010) examined the narrative properties of relationship-defining memories that were not first encounter memories (which were mostly about positive events), but rather memories about the most positive and most negative events in the marriage. They found similar results, in that the properties of the relationship-defining memories predicted marital satisfaction. Most of the effects emerged in the negative relationship-defining memories. If the person had found some redeeming outcome from the negative event (e.g., McAdams, 2006), and had made meaning out of the experience (e.g., McLean & Thorne, 2003; Singer, 2004b), they were less likely to feel bad about their marriage. This suggests that the way that negative relationship events, particularly those that are central and definitional to the marriage, are viewed relates to martial satisfaction. One way to approach a negative situation in a marriage is as a unit or a "we" (Skerrett, 2003) as opposed to as an "I".

"We-ness" and Marital Satisfaction

Healthy marriages are represented by cognitive interdependence and the inclusion of the other in one's view of oneself (e.g., Agnew, Van Lange, Rusbult, & Langston, 1998; Aron & Aron, 1997). Couples move from viewing themselves as two separate "I"s together, and to see themselves as a "we" unit. This notion of "we-ness" has been assessed in a variety of ways including scalar-type questionnaires (e.g., Marital Engagement – Type of Union Scale; Chap. 7 by Singer, Labunko, Baddeley, & Alea, this volume), pictorial diagrams (e.g., Inclusion of Other in the Self scale; Aron, Aron, & Smollan, 1992), the extent to which couples, when engaged in conversations have linguistic matching (e.g., Ireland & Pennebaker, 2010), and the use of pronouns in conversations, memories, and descriptions of relationships (e.g., Agnew et al., 1998; Buehlman, Gottman, & Katz, 1992; Honeycutt, 1999; Seider, Hirschberger, Nelson, & Levenson, 2009; Simmons, Gordon, & Chambless, 2005), which is the focus of the study presented below.

The words people speak relate to a variety of physical and mental health outcomes (see Pennebaker, Mehl, & Niederhoffer, 2003 for a review). Pennebaker (2011) has argued that even the words that seem meaningless, or "function words" (e.g., prepositions, articles, pronouns), are meaningful, and perhaps even more meaningful than narrative content. Function words link the content of a conversation, written sentence, or story together. Pronouns are one type of function word, and reflect where attention is being allocated (Tausczik & Pennebaker, 2010): on me (1st person singular pronouns) or on we (1st person plural pronouns), for example. In the relationship-defining memory excerpt at the beginning of this chapter, the content is clear: a woman is describing how resentment built up in her marriage and almost led to divorce. However, a closer inspection of the pronouns used is equally revealing. First person singular pronouns (e.g., I, my) are used to describe the event and breakdown on the bathroom floor (e.g., "*My* husband and *I* were adjusting to life with a newborn"). This statement could have just as easily been, "*We* were adjusting to life with a newborn," but it did not use this construction. However, in

the last three sentences there is a noticeable shift in the way that the woman is talking about the event; her husband becomes an integral part of it. The focus is on the unit, on "we": "*we* didn't want to go through a divorce" and "*our* marriage is stronger today." The use of 1st person plural pronouns thus has the potential to be a natural, implicit indicator of "we-ness" in marital relationships.

In perhaps one of the earliest studies of language use in couples' research, Buehlman and colleagues (1992) conducted oral history interviews with 56 couples (see Honeycutt, 1999 for related research). As part of the larger study, the couples were asked to talk about the "really good times" and the "really hard times" in their marriage. The researchers coded the husband and wife's responses for "we-ness," or how much the spouse identified his or herself as part of a unit or couple.[1] For both husbands and wives, the use of "we-ness" linguistic markers by a spouse was positively related to one's own marital satisfaction, as well as to the satisfaction that one's spouse was feeling about the marriage. A focus on "we" was also a predictor of marital separation and divorce: the less "we-ness" expressed, particularly by the husbands, during the oral history interviews the more likely the couple was to be separated or divorced 3 years later. In the project, however, no attempt was made to compare whether there were differences in the levels of "we-ness" reflected in the good and bad conversations separately. This seems necessary since recent experimental research suggests that the use of "we-ness" linguistic markers and relationship satisfaction seems to vary by situation (Karremans & van Lange, 2008).

"We-ness," reflected by 1st person plural pronouns, however, should probably not be considered in isolation from pronouns reflecting a sense of "me" or "I" in the relationship, or 1st person singular pronouns. The two types of pronouns seem to reflect distinct viewpoints within a relationship (e.g., sharing only 3 % of variance; Seider et al., 2009). In one part of a larger study, for example, Seider and colleagues (2009) asked middle-aged and older married couples to complete marital satisfaction inventories, and engage in a video-taped 15-min conversation about a mutually agreed upon topic of conflict in their marriage. Pronouns reflecting "we-ness" (e.g., we, our) and those reflecting separateness (I, me, you, yours) were coded from the transcribed narratives of the couple's conversations. Contrary to previous work, the researchers found no relation between pronouns reflecting "we-ness" and marital satisfaction. There were effects, however, for the separateness pronouns: the use of I, me, you, etc. was associated with *lower* marital satisfaction for the person who was using those pronouns. This was particularly true for older wives: their use of separateness pronouns was negatively related to their own marital satisfaction. For older husbands, however, it was the wife's use of "I"s and "me"s that was related to their own marital satisfaction. This negative association between "I-ness" and marital satisfaction seems to hold for couples who are in relatively healthy relationships; on the other hand, a positive association between "I-ness" and relationship satisfaction exists for distressed couples (Williams-Baucom, Atkins, Sevier,

[1] It is not clear from the description whether a count of "we" pronouns was used in the coding process, but it seems likely to have been incorporated somehow.

Eldridge, & Christensen, 2010) as well as young, dating couples (Slatcher, Vazire, & Pennebaker, 2008). Thus, "I" might sometimes reflect enhanced self-disclosure (see also Simmons et al., 2005).

The Current Study

This previous research suggests inconsistencies regarding whether "we-ness" and "I-ness," as reflected in pronoun use, is associated with higher or lower marital satisfaction. The length and type of relationship (long-married couples versus dating relationships), the topic being analyzed (i.e., conflicts, instant messages, relationship descriptions), and gender seem to matter. Given these mixed findings, the current study attempted to hold some of these variables constant while simultaneously examining others. The current design included individuals who had been married for at least 2 years (but not to each other) to avoid the potential confound of the recency of marriage on marital satisfaction (McNulty & Karney, 2001). The couples ranged in terms of relationship length, and thus this variable was held constant in the analyses.[2] Finally, we examined what is perhaps one of the most insightful narrative indicators of relationship satisfaction, "relationship-defining memories." These memories tell the story of the relationship: both the good and the bad. It was expected that "we-ness" would be greater in positive relationship-defining memories, and that "I-ness" would be greater in negative relationship-defining memories. Further, we predicted that "we-ness" expressed in both positive and negative relationship-defining memories would be associated with relationship satisfaction because of the centrality of these memories for the relationship. Finally, because the sample was relatively healthy and not recruited from marital therapy clinics, we expected that "I-ness" would be associated with lower marital satisfaction, particularly when expressed in the negative relationship-defining memories. Gender patterns were also explored.

Method

Participants

Participants were men ($n = 99$) and women ($n = 168$) from the Southeastern United States.[3] All participants were married, and had been for a minimum of 2 years. The mean length of marriage was 20.38 years ($SD = 12.93$). Participants ranged in age

[2] Preliminary analyses were conducted to examine whether age and relationship length were differentially related to "I-ness" and "we-ness" in positive and negative relationship-defining memories. No effects were found and thus these variables were not considered further.

[3] Sample sizes vary in analyses due to missing data.

from 20 to 85 years-old (*M* age = 47.19 years, *SD* = 12.32).[4] Ninety-one percent of the sample was Caucasian. Participants were well-educated with an average of 15.33 (*SD* = 2.69) years of education. Participants were also healthy: on a 6-point Likert-scale measure of subjective health compared to own-age peers (Maddox, 1962), participants' average health was 5.06 (*SD* = .87). There was no gender difference in length of marriage, mean age, or subjective health in the sample. Men (*M* = 15.93, *SD* = 2.56), however, were more educated than women (*M* = 14.96, *SD* = 2.70), *t* (247) = 2.78, $p < .01$. Participants were recruited via email from an adult participant pool, as well as graduate, undergraduate, and faculty and staff list-serves at a mid-sized university. Psychology undergraduate student participants received extra credit in a course.

Measures

Marital satisfaction. The 3-item Kansas Marital Satisfaction Scale (KMS; Schumm et al., 1986) assesses the extent to which couples are satisfied with their marriage, with their husband or wife as a spouse, and in their relationship with their husband or wife. Responses are made on a 7-point Likert scale, where 1 is *extremely dissatisfied* and 7 is *extremely satisfied*. Responses to the items are totalled to assess overall marital satisfaction (*M* = 17.66, *SD* = 3.78). Cronbach's alpha was .97 in the current study.

"I-ness" and "we-ness". "I-ness" and "we-ness" were coded from the relationship-defining narratives that participants wrote using Linguistic Inquiry and Word Count content-coding software (LIWC, 2001; Pennebaker, Francis, & Booth, 2001). The program counts the number of words that are representative of several reliable grammatical, psychological, and cognitive categories of written language and verbal disclosure. Two pronoun categories were used in the current study to represent the constructs of "I-ness" and "we-ness" (see also Seider et al., 2009; Simmons et al., 2005 for similar methodology). "We-ness" was represented by 1st person plural pronouns (e.g., we, us, our) and "I-ness" was represented by 1st person singular pronouns (e.g., I, me, mine). The final "I-ness" and "we-ness" variables were calculated as the total proportion of all the pronoun words in a given text.

Procedure

Data were collected as part of a larger online study (SurveyMonkey 1999). After first indicating that they had been married for at least 2-years, participants proceeded to the marital satisfaction questionnaire, followed by approximately 30 min of filler tasks (e.g., episodic memory, vocabulary), and then to the memory-writing

[4] Age was only related to one study variable, length of relationship, r (267) = .79, $p < .001$, which was controlled for in analyses.

portion of the survey. The directions to elicit the relationship-defining memories were adopted and modified from Moffitt and Singer's (1994) work on self-defining memories. The directions asked participants to think about a positive/negative event that happened at least 1 year ago that they experienced together *with their spouse*. In order to emphasize that the memory was a *defining* moment in the relationship, the memory had to meet the following criteria:

> It is a memory from your relationship that you remember very clearly. The memory still feels important to you even as you think about it, and it leads to strong feelings. It is a memory that might be the memory you would tell someone else if you wanted that person to understand the positive/negative aspects of the relationship between you and your spouse. It is a memory about a specific event, but it can be linked to other similar memories that share the same theme. It is a memory that you have thought about. It is familiar to you, like a picture you have studied or a song you have learned by heart.

Participants wrote about their memory in a large text box that expanded as they typed. Standard directions were used to facilitate memory completeness (Alea & Bluck, 2007). The negative relationship-defining memories were always asked before the positive memories for ethical reasons, to help ensure that individuals did not end the survey in a negative affective state. Demographic questions were asked last. Examples relationship-defining memories are provided in Table 9.1.

Table 9.1 Examples of positive and negative relationship-defining memories

Positive relationship-defining memory
A few years back, *we* took a trip to Greece. *We* were on a ship bound for Athens, and stopped over at a few islands on the way. **My** husband had never been anywhere outside of the United States (abroad) and **I** was so excited for him to see and experience this journey. (He was raised in the Greek Orthodox faith and *we* were married in a Greek Church). One of *our* stops was at a tiny island called Kythira. The sea was a gorgeous blue and *we* went ashore to the beach there and swam in the Aegean. After *our* swim, *we* dried off and walked into the village to find lunch. *We* found a tiny little restaurant and they could speak little or no English, so *we* ended up in their kitchen pointing out what *we* wanted to eat – a plate of pasta with tomatoes and a salad of olives and feta. To this day, *we* think it is the finest meal *we've* ever eaten – just because of the freshness and the circumstances and the hospitality of these people. While walking further into the village after *our* delicious lunch, *we* neared an alley with a door open into a little room where a very weathered Greek man sat listening to the most gorgeous tenor/opera type music, resonating through this small alley way. **My** husband and **I** both immediately broke into tears at the beauty of it and the wonderful memory of *our* day, thanking God that *we* were so blessed to be in this time and in this place experiencing this together. *We* talk about this all the time!
Negative relationship-defining memory
I had been suspicious of **my** husband's activities for a while. One Sunday morning **I** finally heard a voicemail left by his girlfriend and knew for sure. When **I** drove up to his gym to confront him, he was still outside in his car, leaning back in the driver's seat with one arm over his eyes, talking on his cell phone. **I** sat in my van within two feet of his car for several minutes before someone got in a nearby car and drove off. He heard that, opened his eyes and saw me sitting there. **I** will never forget the look of shock and fear on his face. **I** said, "you son of a bitch" and drove off, with him following me and trying to call me

Note. Identifying information has been changed. Pronouns in underlined italics are 1st person plural, and those in underlined bold are 1st person singular

Results

Levels of "We-ness" and "I-ness" in Positive and Negative Relationship-Defining Memories

A 2 (type of relationship-defining memory: positive, negative) × 2 (gender: men, women) mixed multivariate analysis of covariance (MANOVA) was conducted. Type of memory was a within-subjects variable. The dependent variables were the proportion of 1st person plural (representing "we-ness") and singular pronouns (representing "I-ness") in the narrative out of the total number of pronouns. Length of the relationship was the covariate. The multivariate type of memory x gender interaction was not significant, Wilk's $\lambda = .99$, F (2, 229) = 1.33, $p > .05$, $\eta_p^2 = .01$. However, main effects existed.

The type of memory multivariate effect was significant, Wilk's $\lambda = .88$, F (2, 229) = 15.73, $p < .001$, $\eta_p^2 = .12$. Results are displayed in Fig. 9.1. Contrary to expectations, there was no significant effect for "I-ness." Positive and negative relationship-defining memories had the same proportion of "I-ness" pronouns, *Greenhouse-Geisser* F (1, 230) = 2.28 $p > .05$, $\eta_p^2 = .01$. There was, however, an effect for "we-ness" consistent with expectations: positive relationship-defining memories had a greater proportion of "we-ness" pronouns than negative memories, *Greenhouse-Geisser* F (1, 230) = 23.38, $p < .001$, $\eta_p^2 = .09$.

The multivariate gender main effect was also significant, Wilk's $\lambda = .97$, F (2, 229) = 3.73, $p < .05$, $\eta_p^2 = .03$. Results are reported in Fig. 9.2. There was no significant univariate gender effect for the proportion of "I-ness" pronouns in the

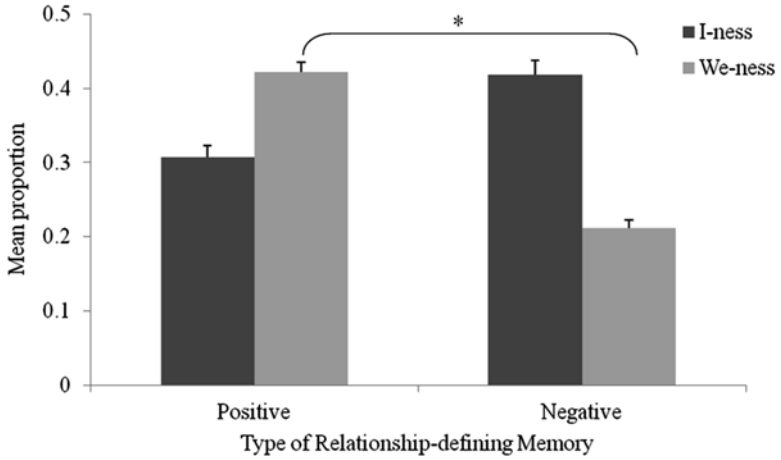

Fig. 9.1 Differences in the proportion of "we-ness" and "I-ness" in positive and negative relationship-defining memories. Marginal means are reported. Covariate in the model is relationship length, $M = 20.50$. * $p < .001$

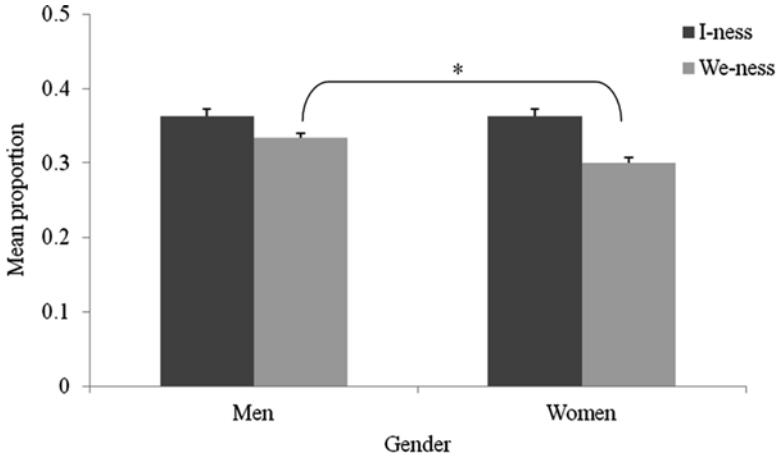

Fig. 9.2 Differences in the proportion of "we-ness" and "I-ness" in relationship-defining memories (across type of memory) for men and women. Marginal means are reported. Covariate in the model is relationship length, $M = 20.50$. * $p < .05$

relationship-defining memories, $F\ (1, 231) < 1.00$. However, there was a significant effect for "we-ness," $F\ (1, 230) = 7.30$, $p < .01$, $\eta_p^2 = .03$. Men had a higher proportion of "we-ness" pronouns in their relationship-defining memories than did women.

"We-ness" and "I-ness" in Relationship-Defining Memories and Marital Satisfaction

The second set of analyses was conducted to examine whether "we-ness" and "I-ness" in relationship-defining memories predicted relationship satisfaction, and if the pattern varied by gender. Regression analyses could not be conducted because the marital satisfaction variable was skewed: the majority of the sample was highly satisfied in their relationship ($M = 17.66$, $Mdn = 18.00$, $mode = 21.00$, $SD = 3.78$). Thus, non-parametric Spearman's rank-order correlations were conducted for the sample as a whole, and for men and women separately.

For *positive* relationship-defining memories, the proportion of "I-ness" pronouns, $r_s\ (247) = -.04$, and the proportion of "we-ness" pronouns, $r_s\ (247) = .10$, were not significantly related to marital satisfaction, $ps > .05$. There was no significant relationship between the proportion of "I-ness" pronouns in negative relationship-defining memories and martial satisfaction, $r_s\ (247) = .00$, $p > .05$, which was contrary to expectation. There was, however, a relationship for "we-ness": as the proportion of "we-ness" pronouns in *negative* relationship-defining memories increased, marital satisfaction also increased, $r_s\ (247) = .16$, $p < .05$.

Table 9.2 Correlations between marital satisfaction and "We-ness" and "I-ness" in positive and negative relationship-defining memories separately for men and women

Relationship-defining memories	Gender	
	Men	Women
Positive: "we-ness"	–0.01	0.16*
Positive: "I-ness"	0.05	–0.02
Negative: "we-ness"	0.10	0.18*
Negative: "I-ness"	–0.01	0.02

Note. Spearman rank-order correlations are reported. Sample sizes vary due to missing data: positive relationship-defining memories: men $n = 88$, women $n = 159$; negative relationship-defining memories: men $n = 87$, women $n = 160$. Men and women did not differ in marital satisfaction
*$p \leq .05$

The correlations between "we-ness" and "I-ness" in positive and negative memories and marital satisfaction separately for men and women are reported in Table 9.2. For women and men, there was no significant relation between the proportion of "I-ness" in positive or negative relationship-defining memories and marital satisfaction. This mirrored results for the sample as a whole. However, for women, two significant relations emerged. The more that "we-ness" pronouns were used in women's *positive* relationship-defining memories, the higher their reported marital satisfaction. "We-ness" was also related to martial satisfaction for women in their *negative* relationship-defining memories. The more that women used "we-ness" pronouns in their negative relationship-defining memories, the higher their marital satisfaction, as was the case for the entire sample. Thus, the pattern found for the sample overall seems particular to women.[5]

Discussion

This chapter focused on the extent to which "we-ness", compared to "I-ness", is expressed in relationship-defining memories by married men and women across adulthood, and whether these constructs predict marital satisfaction. Most previous work examining pronoun use has focused exclusively on negative relationship events (e.g., Seider et al., 2009; c.f., Buehlman et al., 1992) or generic relationship descriptions (e.g., Karremans & van Lange, 2008). We examined both high points and low points in the marriage in order to fully understand the extent to which viewing oneself as part of a unit – a "we" – relates to marital satisfaction. It was found in

[5] Fishers' r to z-transformation was conducted to compare the correlations between "we-ness" and martial satisfaction for positive and negative relationship-defining memories for men and women. The correlations for men and women were not significantly different from one another. However, these non-significant findings should be interpreted with caution because Spearman rank-order correlations were used due to non-normal data.

the current study, as expected, that "we-ness" was lower in negative memories that define the relationship compared to positive memories. Negative moments in relationships, like extremely emotional arguments, dealing with losses, or infidelity, perhaps necessitate separating oneself from the unit, or interdependence of marriage. How can "I" be part of a "we" if he/she did that to me? This is clearly demonstrated in the negative relationship-defining memory example provided in Table 9.1, which did not have a single instance of a 1st person plural pronoun. It may be that the tendency to downgrade past marital satisfaction in favor of current marital accord (Frye & Karney, 2004; e.g., Karney & Coombs, 2000) is also evident in the way that married individuals narrate relationship events. "We" are still together and happy, so this negative event did not happen to "us."

This inclination to separate from the unit during difficult times, however, is not reflected in an increase in "I-ness" in the negative events. We had expected that "I-ness" (i.e., "I" and "me" pronouns) would be higher in negative events compared to positive events. However, contrary to expectations, regardless of whether positive or negative relationship-defining memories were recalled, there was no significant difference in the proportion of using 1st person singular pronouns. Although interdependence in a marriage and including the other in one's self-concept are beneficial for relationship satisfaction (e.g., Agnew et al., 1998; Aron & Aron, 1997), completely losing one's sense of "I" when talking about events that define a relationship does not seem to happen. The individual is still an actor in the relational event.

In accord with this view, "I-ness" represented by the use of 1st person singular pronouns did not show a significant association with marital satisfaction in the current sample overall. This was contrary to what we expected, at least for the negative relationship-defining events. Only "we-ness" predicted marital satisfaction. This was true, however, mostly for *negative* relationship-defining memories, and it was particularly the *women* who were driving this effect. It is considering oneself as a unit during the negative, difficult, and challenging times in a marriage which is associated with better marital satisfaction, particularly for women. This is resiliency in marriage: fostering a sense of "we" even during, or especially during, the difficult times (Skerrett, 2003). Having and successfully overcoming negative events early in a marriage may actually be beneficial for the relationship (e.g., Neff & Broady, 2011), and having a sense of "we" during those difficult times, our work suggests, may be necessary in building strong redemptive themes (McAdams, 2006).

The strong relation of "we-ness" to marital satisfaction for women in relationship-defining memories is opposite to what has been found in previous research where focusing on "we" when discussing pleasant and conflict topics in the marriage was more important for men's relationship satisfaction (Buehlman et al., 1992). However, we suspect that the pattern of gender differences that emerged in our work was because *memories* were the focus of the content analysis. Women enjoy purposeful reminiscing more than men and do so with more ease (e.g., Davis, 1999), have qualitatively richer autobiographical memories (e.g., Ross & Holmberg, 1992), and are more likely to benefit in terms of relationship intimacy and satisfaction when recalling autobiographical events about their relationship (e.g., Alea & Bluck, 2007;

Alea & Vick, 2010). Memories are more likely to serve a social-bonding function for women compared to men (Alea & Bluck, 2003). Thus, any future research, or even perhaps clinical work, which uses relationship-defining memories as a way to explore "we-ness" in relationships, would need to consider this gender difference.

Future Research and Clinical Implications

The findings of greater numbers of "we" pronouns in positive memories, and of a relation between "we-ness" and marital satisfaction in women's relationship-defining memories, in particular, regardless of memory valence, point to several future research directions and implications for clinicians working with couples in therapy (Singer & Skerrett, 2014). Longitudinal work is needed, since the current study and much of the previous research are only providing a moment-in-time assessment of relationship satisfaction and a person's sense of "we-ness" when describing moments in the relationship. The longitudinal work that does exist comes mostly from Gottman and colleagues. For example, a close examination of Buelhman and colleagues' (1992) longitudinal study indicates that "we-ness" by husbands and wives is more strongly related to relationship satisfaction when the two constructs are assessed concurrently. Three-years after "we-ness" expressed during the discussion of conflict topics in the relationship was assessed, the relation to relationship satisfaction was lower, and for the wives in the study, the relation went away. The wives' "we-ness" at initial assessment did not predict relationship satisfaction 3 years later. Thus, future work should consider whether there is a long-term and perhaps cumulative impact of using "we-ness" when remembering the difficult times.

Experimental manipulations would also help to further elucidate the potential causal link between "we-ness" and "I-ness" in relationship-defining memories and relationship satisfaction. One example might be a study that instructs participants to explicitly focus on either "we" or "I" when remembering negative and positive relationship-defining moments, and assesses relationship satisfaction before and after the manipulation. This approach would also allow researchers to examine whether having too great a sense of "we" when remembering relationship events may actually be problematic. Currently the assumption is that greater "we-ness" is better, but perhaps there is an inverted U-shaped function, and that there is an optimal amount of "we-ness" that is beneficial for relationship satisfaction. Another program of experimental work might examine whether there is something unique about levels of "we-ness" and "I-ness" expressed when remembering relationship-defining memories specifically, versus other types of memories (i.e., neutral moments in the relationship, daily routines, etc.) which could act as a control condition (see Alea & Bluck, 2007 for a similar approach).

There are obvious clinical implications that arise out of the current work. First, in our clinical experience, most couples in distress have lost track of a relational language. As Gottman and DeClaire (2001) have demonstrated, a language of

"finger-pointing" and defensiveness prevails, highlighting one's personal grievances and the offenses inflicted by one's partner. Interventions that shift the couple's focus back to experiences of togetherness and to a vocabulary of "we-ness" have the potential to break this damaging cycle of separateness. At the same time, clinicians in the assessment phase of the couple can look for moments of "we" language during couples' accounts of negative relational memories and "tag" these expressions of unity as indicators of potential resilience for future shared work by the couple. Partners in the heat of frustration with each other may focus on their moments of discord, while neglecting ways in which they still depict their relationship in strong relational terms. The data presented in this chapter highlight that attention to this subtle phrasing, especially during negative recollections, may be a window into positive reclamation of the relationship. Even more, and congruent with our recent studies of mutuality assessed by the ME (To US) in married couples (Chap. 7 by Singer et al. (2015), this volume), the current results point to the fact that women who perceive more active engagement by their spouses in the various activities of the relationship (more instances of "we" and mutuality) are likely to express more satisfaction in the relationship and hope for its improvement.

In conclusion, the clinical use of relationship-defining memories and linguistic assessments of "we-ness" in a couple's description of relationship events seems promising. More empirical work to determine whether "we-ness," compared to "I-ness," can actually change and improve feelings within a marriage is necessary. The most obvious direction is to begin experimental clinical-trial type work where men, and especially women, are trained and encouraged to find and narrate the "we" in relationship events, particularly those events that were difficult and are tarnished with instances of blame and finger pointing. These are the moments when "we-ness," and a sense of unity and mutuality, are perhaps difficult to envision and express, but it may be precisely at these moments that "we-ness" is most necessary for marital happiness and resilience of a marriage over time.

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Chapter 10
Forgiveness: A Route to Healing Emotional Injuries and Building Resiliency

Catalina Woldarsky Meneses and Leslie S. Greenberg

Introduction

Because we often hurt the ones we love the most, we need to understand how to repair the damage that occurs when there has been an emotional injury (i.e. betrayal) in a close relationship. Forgiveness is a powerful process that involves the transformation of negative emotional states to affiliative states characterized by compassion and empathy for the perpetrator (Malcolm et al., 2005). Over the past decade, the role of forgiveness in psychotherapy has received much attention. In couples, forgiveness has been found to increase marital satisfaction, psychological closeness, relationship investment and re-balance the couple's power distribution (Fincham, Beach, & Davila, 2004; Friesen, Fletcher, & Overall, 2005; Gordon & Baucom, 2003; Makinen, 2004). The purpose of this chapter is to outline the process of forgiveness in Emotion-focused couple therapy (EFT-C) (Greenberg & Goldman, 2008; Greenberg & Johnson, 1988; Johnson, 2004) based on empirical investigations that involved in-depth observations of the processes and patterns that seemed to distinguish couples who successfully resolved their betrayals via forgiveness versus those who did not. Our initial study culminated in the construction of the Couples Forgiveness Model (Woldarsky Meneses & Greenberg, 2011). Five components from this model were found to distinguish the two groups and are outlined in this chapter in light of existing forgiveness research. We argue that from an EFT-C perspective the injuring partner's shame about the injury and the injured partner's accepting response to the shame play a critical role in the process of couples' forgiveness.

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While there is deep beauty in the closeness that an intimate relationship can bring, there is at times also intense pain when that deep bond is violated. An emotional injury (EI) encompasses any event that transgresses the expectations of a close relationship, which leaves one partner with enduring unresolved feelings of hurt and anger due to a violation of trust. These betrayals take diverse forms, including infidelity, abandonment at time of need (e.g., death of a parent), criticism at a time of vulnerability, and they represent violations of the expectations set in place by the emotional bond based on attachment and identity needs that govern intimate relationships (Greenberg & Goldman, 2008).

For close to a decade, we have been studying video-taped sessions of Emotion-focused Couple Therapy (EFT-C; Greenberg & Goldman, 2008; Greenberg & Johnson, 1988) to explore the process of how couples forgive and overcome the pain that arises when a relational bond is damaged by an emotional injury. An empirically-based model of forgiveness emerged from this line of research, which highlights the adaptive nature of the experience and the expression of shame by the injurer in restoring relational bonds.

Forgiveness Research in Psychotherapy

Forgiveness is a complex process involving profound transformation that includes both cognitive and affective shifts, and results in an affiliative stance towards the injurer. In this process, the injurer is no longer seen as "all bad" and is instead understood as a multi-dimensional being whose actions were wrong, and rather than eliciting anger, hurt and desire for revenge, the injurer now evokes a sense of calm and empathy. Indeed, forgiveness is health promoting and it is now being facilitated as an intervention at an individual level (e.g., incest and abuse survivors; distressed couples) (Freedman & Enright, 1996; see Wade & Worthington, 2005 for a review) and also at the group level where there has been mass violence, human rights abuses and war (Kaminer, Stein, Mbanga, & Zungu-Dirwayi, 2001). Positive findings have also been documented in cases where forgiveness was not an explicit goal of therapy (Chagigiorgis & Paivio, 2005; Malcolm & Greenberg, 2000). Worthington and colleagues (2007) have found that forgiveness has positive effects on health and well-being, as it seems to counter the impact of stress, hostility and rumination on the body, in part due to the activation of positive emotions that calm the nervous system. Over the years, interest in understanding the process of forgiveness has yielded a number of different models, most of which are theoretically rather than empirically-based (i.e., Hargrave, 1994) or in cases where research data were considered in the development of the models, this was done from a top-down approach moving from theory to data (i.e., Gordon & Baucom, 1998, 1999). Alternatively, research findings were used post-hoc to identify characteristics of couples that forgive from those who do not (e.g., Makinen & Johnson, 2006; Millikin, 2000). While these models contributed to the field's understanding of forgiveness, questions about how the process actually unfolds remained to be investigated. Thus, we set out

to observe, measure and articulate the chain of events that occurs en route to forgiving. Using a task-analytic approach (Greenberg, 2007; Rice & Greenberg, 1984), we conducted a series of studies in an effort to identify the key affective processes that give rise to interpersonal forgiveness. In this project 10–12 sessions of EFT-C were offered to nearly 50 couples that participated in the York Emotional Injury research project (Greenberg, Warwar, & Malcolm, 2010). Couples were community members from a large urban area, who were committed to staying in the relationship and wanted to move beyond the unresolved emotions that related to an EI, which had occurred at least 2 years prior with the same partner. In brief, our interest was in studying couples "stuck in unforgiveness" in order to investigate the evolution of the forgiveness process. Prior to discussing the details and implications of our research findings, we summarize our therapeutic approach.

Emotion-Focused Couple Therapy

Emotion-focused couple therapy (EFT-C) is an affective systemic approach that considers emotion regulation to be a primary function of coupling, and proposes that motivation in intimate relationships revolves around the systems of attachment, identity and attraction (Greenberg & Goldman, 2008). From this perspective, couples' conflict is understood as emerging most fundamentally from unmet adult needs for attachment (proximity, availability and responsiveness), and identity (having one's sense of self, agency and status accepted and validated). Conflict resolution is achieved by emotion regulation that occurs via the disclosure of underlying, vulnerable feelings and by other-soothing (i.e., responsiveness and empathic validation of these feelings), as well as self-soothing.

According to the EFT-C framework the emotional system is a biologically based meaning system that is fundamentally adaptive (Greenberg 2002, 2004; Greenberg & Goldman, 2008; Greenberg & Johnson, 1988). Extending on the conclusions of Fridja (1986), emotions are seen as playing an essential role in our daily functioning. Emotions tell us if our needs are being met or not (Greenberg, 2002), rapidly give us information about our reactions to situations and guide our action tendencies. They are also our primary communication system. Indeed core attachment and identity concerns evolve and are activated by emotions (Greenberg & Goldman, 2008; Greenberg & Johnson, 1988). In EFT there are four distinct categories of emotion: primary adaptive, primary maladaptive, secondary and instrumental (Greenberg & Safran, 1987). *Primary adaptive emotions* refer to one's most basic emotional response to a given situation. For example, an experience of sadness would signal a need for comfort, inclining the experiencer to seek nurturing from others (or self). The action tendency and needs embedded in these emotions serve as guides to what is occurring in relationships. *Primary maladaptive emotion* refers to a primary emotional response that was once adaptive but is currently maladaptive. Emotion typically becomes dysfunctional when a person has a negative or traumatic experience that remains unprocessed (Greenberg, 2002). As a result,

neutral stimuli are filtered through the lens of past emotional experience (emotion schemes), triggering painful feelings. The resultant emotions do *not* provide information that promotes adaptive responding as they are grounded in the past, often lacking relevance to the current situation. Primary maladaptive emotions are typically overwhelming and cause distress; the most frequently observed in therapy include *shame* and *fear. Secondary emotions* (Greenberg & Safran, 1987) are reactions to initial, primary emotional experiences and obscure primary emotions (Greenberg, Rice, & Elliot, 1993). They also distance the person from the core emotion that elicits the secondary reaction. For example, expressing rage when feelings of shame are activated. Finally, *Instrumental emotions* refer to learned responses used to influence the behaviour of others. For example, using anger as a means of gaining power, or vulnerability to elicit sympathy.

Distressed couples generally express secondary emotions, which are reactions to their more primary emotions, and unmet needs. This tendency often evolves into rigid interactional patterns or negative cycles of interaction that are self-reinforcing and become repetitive over time. Thus, having partners express and respond affiliatively to each other's underlying security and identity-related emotions (e.g., fear or sadness underneath the anger; shame underneath the contempt) is the key to interactional change. Couples who have experienced an EI often develop two negative interactional cycles: the more recent cycle reflecting the couples' way of handling the EI, and the relational cycle that predated the couple's EI. In helping couples heal from an EI, the therapist must explore the impact of the EI on both of these cycles. Therapists also aim to facilitate the expression of an apology by the injuring partner that includes either shame (for the EIs resulting from a violation of a sacred value, e.g., infidelity) or empathic distress (for the EIs that result from violating other values, e.g., financial deception) (see Woldarsky Meneses & Greenberg, 2011 for further details).

Investigating the Process of Interpersonal Forgiveness in EFT-C

Our initial study represented the discovery-oriented phase of the task analysis (Woldarsky Meneses & Greenberg, 2011) and focused on the intensive analyses of six couples: four of whom were able to forgive one another and two who were not. The result was the construction of an empirically-based model of interpersonal forgiveness derived from observations of the actual process of change of these six couples. Moreover, a rating system of the observed in-session "steps" that led to forgiveness was developed. Common processes that were reliably found by independent raters to discriminate forgiving couples from the non-forgiving couples (presented in yellow in Fig. 10.1) included the injuring partner's (1) accepting responsibility for the emotional injury in a non-defensive way; (2) expressing shame; (3) offering a heart-felt apology; and (4) the injured partner's experiencing a shift in his/her view of the injuring partner; and lastly, (5) the injurer accepting forgiveness.

The subsequent study represented the validation phase of the task analysis (Woldarsky Meneses & Greenberg, 2014). Its aim was to assess the impact that three steps or "components of resolution" of the previously developed model had on

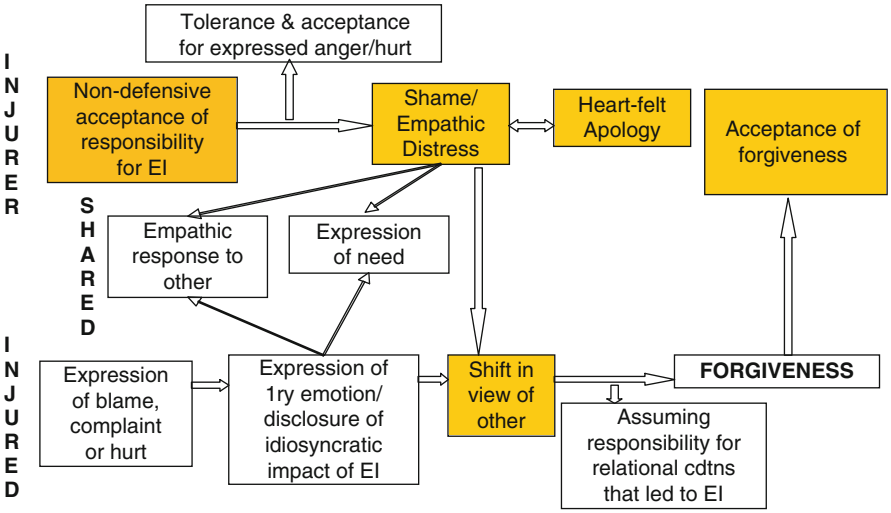
Tolerance & acceptance for expressed anger/hurt
INJURER
Non-defensive acceptance of responsibility for EI
Shame/ Empathic Distress
Heart-felt Apology
Acceptance of forgiveness
SHARED
Empathic response to other
Expression of need
INJURED
Expression of blame, complaint or hurt
Expression of 1ry emotion/ disclosure of idiosyncratic impact of EI
Shift in view of other
FORGIVENESS
Assuming responsibility for relational cdtns that led to EI

Fig. 10.1 The Couples' Forgiveness Model (Woldarsky Meneses & Greenberg, 2011. NOTE: *Highlighted boxes* denote components that distinguished the resolved from the unresolved couples in the discovery-oriented phase of the task analysis of couples' forgiveness

treatment outcome. The three components tested were (1) the injuring partner's shame; (2) the injured partner's acceptance of the shame (derived from the combination of "empathy" and "shift in the view of other", two components from the original model); and (3) the injured partner's in-session expression of forgiveness.

The rationale for testing these components was based on the observation that the core processes of forgiveness appeared to be the injuring partner's expression of shame and the injured partner's response to the shame. This was supported by clinical experience, where it was observed that the expression of shame led to a new view and a new response by the injured partner, and by research on the adaptive function of shame in repairing relational bonds (de Waal, 1986; Keltner, Young, & Buswell, 1997). In addition, moments of in-session forgiveness were measured in the more recent study in order to assess how the experiential expressions of forgiveness were able to predict the injured partner's forgiveness score, as measured by the Enright Forgiveness Inventory (EFI; Enright, Rique, & Coyle, 2000). Two additional measures were included: the Dyadic Adjustment Scale (DAS; Spanier, 1976) to measure marital distress and the Interpersonal Trust Scale (Trust; Rempel, Holmes, & Zanna, 1985) to measure trust.

There was also a methodological concern that testing each of the five components individually would be challenging given their high degree of overlap. Specifically, the injuring partner's "Non-defensive acceptance of responsibility for the EI", as well as the "Heart-felt apology" often emerged during moments of shame. In keeping with the EFT-C perspective, the emotional process underlying the taking of responsibility for the EI and the heart-felt apology was of key interest. Thus, the injured partner's expression of shame became the primary target, in combination with the response to the shame and furthermore, the in-session expression of forgiveness.

Methodological details of our work are beyond the scope of this chapter (see Woldarsky Meneses & Greenberg, 2014). The focus here is to provide the reader with an overview of what was observed and measured from video-taped therapy sessions by outlining the criteria established to measure the three components studied.

The injuring partner's shame included verbalization of shame, namely remarks about how the EI has left him/her feeling defective or inadequate, as well as an expression of responsibility and regret for the EI. These verbalizations were offered with an internal focus (speaking in "I"), and in a non-defensive, non-hostile manner, and accompanied by gaze aversion (i.e., downcast eyes); covering of the face and at times also tears. This expression was not a pull for comfort and/or an attempt to prevent the injured partner from continuing to talk about his/her pain. In other words, shame about the EI was differentiated from self-blame or expression of shame for the purpose of "self-flagellation", which entails a sense of punishing oneself.

The injured partner's acceptance of shame included an overt expression of understanding and validation of the injuring partner's shame. The response was characterized as affiliative rather than hostile (i.e., not attacking, disregarding or invalidating the injuring partner).

Acceptance communicates an attitude of "genuine, non-critical interest, and tolerance" for the other (Greenberg, 1994, p. 62; Rogers, 1980). It can provide a corrective emotional experience in large part because it makes a person feel validated, as it conveys that the person is worthy of respect, of being heard and that their thoughts and feelings make sense (Greenberg, Elliot, Watson, & Bohart, 2001).

Acceptance of an expression of vulnerability (in this case shame) can be immensely healing and is highlighted as a critical factor for success in couples therapy across theoretical orientations (see Snyder, 1999 for a review; Greenberg & Johnson, 1988; Jacobson & Christensen, 1996) often associated with the ability to be empathic. While the link between acceptance and forgiveness has not been examined per se, the link between empathy by the injured party and forgiveness is well noted in the literature. It is theorized that upon hearing the injurer's apology, the injured person recognizes that the injurer is feeling guilty and therefore feels empathic towards him/her, which promotes forgiveness (Baumeister, Stillwell, & Heatherton, 1994; Hill, 2010; McCullough, Worthington, & Rachal, 1997; Worthington, 1998).

In-session forgiveness was captured in the injured partner's verbalizations that revealed a decrease of anger and hurt, as well as a desire to heal and move forward. Baumeister, Exline, and Sommer (1998) have differentiated between different forms of forgiveness – one that is termed "silent forgiveness", involving the transformation that comes with forgiveness but is not accompanied by the behavioral expression of forgiveness; and "hollow forgiveness" (also termed pseudo-forgiveness), involving the outward expression of forgiveness without any internal transformation. Thus, an overt expression of forgiveness was thought to be highly relevant in this study rather than simply relying on the information reported in the outcome measures.

Pre-treatment level of marital distress. In addition to examining the impact of three components selected from the 2011 model, the couples' pre-treatment level of marital dissatisfaction (or distress) was taken into consideration. Based on previous research in EFT-C showing that emotional processes occurring in-session emerge regardless of the distress level that couples initially report (Ruse, 2002), we expected that the impact of the in-session processes would predict outcome beyond marital distress levels.

Regression analyses were conducted to assess the individual and cumulative contribution that these components of the forgiveness process possess. Given that our interest was in assessing a particular sequence of components, the following order was consistently used in the hierarchical regression models: pre-treatment DAS was entered in step 1, the injuring partner's shame was entered in step 2, the injured partner's accepting response to the shame was entered in step 3, and the injured partner's expression of forgiveness in-session was the final step in the models. The residual change scores on the EFI, DAS and Trust scale were entered as the dependent variables.

The results of the validation study revealed that the injuring partner's shame in combination with the injured partner's acceptance of the shame, and expression of in-session forgiveness predicted approximately 50 % of residual change on the EFI score. Specifically, 33 % of the outcome variance on the EFI was attributed to the injuring partner's expression of shame. An additional 9 % of outcome variance was accounted for with the inclusion of the injured partner's acceptance of shame to the regression model, while in-session forgiveness explained another 8 % of residual change on the EFI. These results are presented in Table 10.1.

Table 10.1 Hierarchical regression analysis for shame, acceptance and in-session forgiveness predicting residual change on EFI

Variable	Total R^2	R^2 change	F change	df	β std.
Step 1:					
Pre-tx DAS	0.002	0.002	0.077	1, 31	0.050
Step 2:					
Pre-tx DAS					0.186
Shame	0.330	0.327	14.634	1, 30	0.588**
Step 3:					
Pre-tx DAS					0.139
Shame					0.460**
Acceptance	0.417	0.088	4.364	1, 29	0.322*
Step 4:					
Pre-tx DAS					0.099
Shame					0.464**
Acceptance					0.094
Forgiveness	0.495	0.078	4.320	1, 28	0.363*

*$p < .05$; **$p < .01$

Table 10.2 Hierarchical regression analysis for shame, acceptance and in-session forgiveness predicting residual change on DAS

Variable	Total R^2	R^2 change	F change	df	β std.
Step 1:					
Pre-tx DAS	0.000	0.000	0.000	1, 31	0.000
Step 2:					
Pre-tx DAS					0.105
Shame	0.196	0.196	7.300	1, 30	0.455**
Step 3:					
Pre-tx DAS					0.052
Shame					0.308
Acceptance	0.311	0.115	4.840	1, 29	0.368*
Step 4:					
Pre-tx DAS					0.012
Shame					0.313
Acceptance					0.146
Forgive	0.385	0.074	3.372	1, 28	0.354

*$p < .05$; **$p < .01$

In addition, changes in levels of martial distress (see Table 10.2) were found to depend heavily on the injured partner's acceptance of the injuring partner's shame. While the injured partner's expression of shame significantly predicted change on the DAS, accounting for 20 % of the variance, shame became a non-predictor when the regression model included the injuring partner's response to the shame. Interestingly, acceptance of shame was uniquely responsible for predicting 31 % of the variance in change on the DAS.

In terms of predicting changes on the Trust scale, none of the regression models tested were found to be statistically significant. Perhaps the use of sub-scale scores would have been more appropriate for the regression analyses or perhaps changes on trust levels following an EI needs to be examined in an alternate manner.

The Role of Shame in Interpersonal Forgiveness

Results from our studies indicate that the essence of the process that leads to forgiveness lies in the injuring partner's ability to express shame in a vivid manner (i.e., offer an emotional rather than intellectual response), and to then have this shame "accepted" by the injured partner. The combination of these emotional processes has been observed in clinical practice and was elaborated upon by Hill, Hasty, and Moore (2011). According to these authors, "shame that is openly expressed facilitates the discovery of wholeness and relational healing, which is the embodiment of forgiveness" (p. 48). Furthermore, Hill and colleagues (2011) argue that differentiation of the Self (Bowen, 1978), which involves managing anxiety and

retaining individuality while remaining in meaningful contact with a significant other (i.e., respecting one's limits while negotiating relational differences) is what permits an offender to be vulnerable and express shame, and it is also the mechanism that allows the injured partner to experience empathy for the offender and in this way "discover" forgiveness.

In order to appreciate the adaptive function of shame in restoring relational damage, its evolutionary role must be understood. Shame is an emotion that evolved to maintain a person's connection to his/her group (in this case the dyad), and "informs one that other people will not support one's actions, that one has broken a very basic social norm… that one has violated standards or values that one recognizes as deeply important" (Greenberg, 2002, p. 145). The expression of shame typically includes a downward averted gaze, blushing, lowered lip corner, body collapse and avoidant or closed posture, which can be reliably identified as shame by observers across cultures (see Keltner & Harker, 1998 for a review). Our work highlights that shame is an appropriate response to a moral transgression. It is considered to be a gesture of appeasement linked to a decrease in aggressive and punitive tendencies from the group (de Waal, 1986). Shame has also been found to evoke affiliative tendencies from observers, including sympathy (Keltner et al., 1997), which is associated with altruistic behaviours that lead to social approach, forgiveness and reconciliation. As shame becomes more socially and cognitively differentiated, it becomes related to a view of one's self and an evaluation of one's worth.

In experimental research, shame has been found to be more effective than guilt at repairing serious transgressions in the context of close friendships and also in public relationships (Giner-Sorolla, Castano, Espinosa, & Brown, 2008; Hareli & Eisikovits, 2006; Iyer, Schmader, & Lickel, 2007). Some controversy exists in the field, however with many researchers insisting that expressing guilt rather than shame is the key to forgiveness. Shame involves the evaluation of *self* as defective, whereas guilt involves the evaluation of *one's actions* as negative (Lewis, 1971). Researchers interested in the social-personality aspect of forgiveness typically measure guilt and shame-proneness based on self-report questionnaires that typically describe brief scenarios and potential "injuries" that one would encounter in every day life (e.g., taking a stranger's parking spot). The participants in our studies, on the other hand, came to therapy having suffered or committed profound injuries that severely impacted the primary adult attachment relationship, which some consider to be a trauma with a small *t* (Shapiro & Maxfield, 2003). Thus, it may be that shame's adaptive function in promoting interpersonal forgiveness is based on the severity of the injury. In other words, an admission of culpability (guilt) and an action tendency to make reparation is not as powerful as self-abasement (shame) and the tendency to shrink away from public gaze when it comes to repairing a serious transgression.

Witnessing the offender express his shame and pain over the injury signals to the injured partner that he or she too is hurting as a result of having committed the injury and violated his or her own moral standards. According to W. M. Malcolm (Personal communication, 2006), shame can be conceptualized as *self-focused* regret that goes beyond guilt, which represents *other-focused* regret. In guilt, the

action tendency is to make reparation but in the context of couples' injuries it can be seen as a form of appeasement motivated by the injuring partner's desire to reconcile. On the other hand, if the injuring partner is able to fully embrace and assume responsibility for the lack of integrity that gave way to the EI (i.e., experience distress resulting from the dissonance between the view of one's self and one's actions) the injuring partner is probably viewed as less likely to engage in the hurtful action again. Shame thus signals that the likelihood of the injury being re-committed is minimal, as the impact of the EI has evoked a change in the offender's identity. However, shame is only adaptive in restoring a rupture when it is not expressed as an attempt to evoke responsiveness (i.e., expressing it with the hopes that it will evoke a compassionate response from the injured partner) or is not expressed as an opportunity to punish oneself by attacking one's flaws (i.e., self-berating; self-contempt). Ultimately for shame to lead to healing, as shown in this study, it must be a self-focused process where there is a sense of feeling bad or worthless about having injured a loved one. From the theoretical framework of EFT-C, this can be understood as a process involving an *intrapersonal* re-organization in the *identity domain* of the injurer.

Expressing shame for damage caused to the relationship also serves to validate the pain of the injured partner. It is a powerful way of emotionally responding to the other person's suffering, as to some degree there is a matching in the intensity of the pain. There is a type of balancing of the ledger of suffering (Böszörményi-Nagy & Krasner, 1986) as the injured partner feels that justice has been served by the injurer suffering for the suffering he or she caused.

Acceptance of Shame: Implications for Forgiveness

As previously noted, accepting the injured partner's shame promoted forgiveness. This finding converges with a key principle of EFT-C: an expression of emotional vulnerability evokes a *softening* response from the other partner, promoting the de-escalation of conflict, which will engender greater connection (Greenberg & Goldman, 2008; Greenberg & Johnson, 1988). As highlighted in EFT-C, people are fundamentally relational beings, who need contact, comfort for security and empathic affirmation in order to have confidence in who they are (Greenberg & Goldman, 2008). In the moments where there is acceptance of the injuring partner's shame, s/he likely experiences a sense of soothing of his or her pain. However, what may have a greater impact on forgiveness is the validation that is offered through acceptance. That is, accepting the injuring partner's shame serves to validate that he really was the person who caused severe damage to the relationship. Accepting the injured partner's pain actually invites change, as acceptance and change exist in a dialectical tension (Greenberg, 1994; Linehan, 1997). In moving towards acknowledging and appreciating the injuring partner's suffering, the injured partner's feelings and view of the injuring partner are transformed. The injuring partner is no longer seen as "all bad", but instead as a complex, three-dimensional human being

(Akhtar, 2002; Malcolm & Greenberg, 2000). Similarly, a deeper understanding of the EI and a more balanced, integrative view of the relationship emerge. Thus, forgiveness is not merely an act of will, but rather a complex psychological and relational process that is discovered through empathy (Hill, 2010), and the acceptance of the injuring partner that underlies empathy.

Impact of the EI and Forgiveness on the Couple's Identity

With an EI and its healing comes a radical shift in the couple's identity and sense of "we-ness" (Reid, Dalton, Laderoute, Doell, & Nguyen, 2006). We-ness reflects the internalization of the relationship within each partner's sense of self, including a recognition of the thoughts, feelings and experiences of the other, the self in relation to the other, and the ways in which these interact to create the relationship dynamics between partners. An EI disrupts the stability of the couple as it shatters assumptions about the safety of the relationship and an understanding of who each partner is. Thus, the sense of "we-ness" is altered and it is reconstructed through the process of forgiveness. As the impact of the EI is processed between the partners – with the injuring partner's shame or empathic distress inviting a transformation of the injured partner's anger into empathy – new information is assimilated about the underlying experience of each partner and his/her capacity to respond to the other's pain. Our sense is that the healing process serves to alter the affiliative aspect of "we-ness", which is encapsulated in the *new* narrative that emerges with forgiveness, and evolves as the couple reconciles and focuses on rebuilding their relationship.

In this process, the couple constructs a new, more positive relational narrative that is characterized by the theme of healing and the experience of having transcended the injury. This narrative shift allows for the final layer of interactional work to unfold – that is the restructuring of the core cycle and the enactment of a new one enabling the couple to move forward and to discuss/ negotiate existing relationship stressors or issues. Idiosyncratic metaphors for the couple's healing arise and become part of a shared narrative that reflects a new sense of "we-ness". For one couple in our study, for example, forgiveness invited a sense of freedom and flexibility in the couple's relational dynamics, which had been previously crystallized by the EI: "It was like we were frozen in time and everything seemed to revolve around the event, all the fights and all the discussions, but in forgiving it feels as though we are thawing and coming back to life, back to being who we were before the event". For another couple in our study, arriving at forgiveness invited the opportunity to reflect on the conditions that gave way to injury, including their pre-EI relational dynamics, and also to acknowledge the sense of loss that accompanied seeing the injured partner in a different light:

> It just made me realize that there were problems in the in the relationship that I knew were there but he didn't talk about them and I let him not talk about them. I mean I saw him unhappy and I often thought that he would leave me not that he would have an affair. And then for me this has meant letting go of a part of him that I once saw. You know because he

> really goes out of his way to help people at times, he can be very selfless and I remember thinking that he had a certain, almost a moral code that he lived by that I really admired – and that was completely shattered. So in a way this has also been about letting go of this big part of him that I was attached to, and somehow understanding him differently. I understand how it could've been for him, not that I was okay with what happened but I can see how it was for him. So, I'm forgiving in many ways and the pain is starting to go away and get left in the background. I don't think I'll ever trust him the same way again [but] I think as time goes on I'll trust him more and more.

In our view, the ability to forgive and reconcile is an indicator of a couple's resilience. While we have focused almost exclusively on forgiveness, we recognize that reconciliation is of great importance and is often the outcome of forgiveness. Reconciliation can be understood as a re-establishment of the relationship at an intimate level, which carries with it both hope and optimism for the future, but also recognition that the relationship will never be exactly the way it was prior to the EI. Fortitude is needed to empathize with the injuring partner, to put aside one's fears of being injured again, and to have faith in the couple's ability to heal and grow instead. Reconciliation can also be understood as a re-affirmation of the commitment to the couple.

Obstacles to the Process of Forgiveness

Barriers to expressing shame. We observed that there were some injuring partners who had great difficulty apologizing or expressing shame and at times even taking responsibility for the EI despite their spouses' vivid expressions of hurt and suffering, and their pleas to seek emotional expressions of regret for the injury. Some injuring partners seemed to have narcissistic tendencies and had great difficulty confronting their shame or expressing it to their partners, perhaps out of fear that this would communicate submissiveness. Not only does shame involve the seemingly unbearable task of confronting one's flaws and errors, its public expression involves taking a "one-down" position in the eyes of others. The work of Hareli, Shomrat, and Hess (2009) supports this claim. They found that observers rated men who expressed a neutral and/or angry face as being more dominant than men whose facial expressions reflected sadness or shame. Thus, not expressing shame allows a person to remain in a position of power. In cases where the injured partner could not express shame for the EI, it was indeed noted that the couple struggled with issues of power, where one partner defined reality in the relationship and the other submitted (i.e., the primary negative interactional cycle was one concerning "identity" rather than attachment needs; Greenberg & Goldman, 2008).

The barriers to accessing shame in these cases can be further explained by the findings of Van Kleef and colleagues (2008). These researchers found that individuals who are perceived as powerful have a tendency to feel less distress, exhibit greater autonomic regulation in response to seeing another person's suffering, and express less compassion compared to individuals with a low sense of power. The authors argue that this reflects a lack of motivation to maintain social connec-

tions. This may contribute to the stability of power hierarchies, as high-powered people show less "low status" emotions when confronted with another person's distress, which serves to reinforce their social power (Van Kleef et al., 2008).

The difficulty with re-building trust or considering re-establishing an intimate connection with someone who has not expressed shame is that there is no safeguard in place that will ensure that the injuring partner will not offend again. In reviewing research findings in the area of antisocial behaviour, Keltner, Haidt, and Shiota (2006) conclude that a deficit in self-conscious emotions that serve an appeasement function (such as shame) relate to the tendency to fail to adhere to social and moral standards. It seems that human beings have an implicit detection system for trustworthiness based on emotional expressions or lack thereof.

Shame vs. Shaming An interesting sequence was observed in cases where the injuring partner avoided expressing shame: the injured partner expressed contempt when she felt that her hurt was not being acknowledged or fully appreciated, and then moved to making hostile attempts to push the offender into expressing shame by making critical attacks on the injured partner's character (e.g., "what kind of a man just sits there and watches his wife cry… you must be sick or dead inside"). So strong is the need to have the pain and suffering from the EI validated that when the injuring partner does not express shame, the injured party will try desperately to elicit it eventually reverting to contempt. The empirical work of Smith, Webster, Parrott, and Eyre (2002) supports this observation. They found that in the context of workplace offences when a transgression is exposed publicly and the offender seems untroubled by his/her behaviour, then it is very likely for the environment to shame that person. In other words, it becomes the task of another person to try to induce shame in this person through admonishment and its accompanying public exposure. Shame is likely to be elicited if the claims made by the environment seem to fit; however, if the offender feels that the public exposure is unjustified or unnecessary then he/she will likely feel humiliated and react with hostility.

Barriers to Accepting Shame Unresponsiveness to the injuring partner's shame represents another challenge to the process of forgiving. In 3 of the 33 cases studied, an unexpected pattern emerged: the injuring partner expressed shame and the injuring partner expressed non-acceptance. Further investigation of these cases revealed that they were characterized by a high degree of marital distress pre-treatment, the injuries involved husbands who had extra-marital affairs and wives (injured partners) who were dominant in the relationship and who did not forgive (as noted on the lack of change from pre to post therapy on the EFI) yet remained in the marriage up to the 3-month follow up period. While no explicit hypotheses were made or tested about how dominance may be related to forgiveness, it is speculated that the pre-injury power distribution in the relationship was out of balance and was a source of distress within the relationship as both partners were fighting for control over the definition of reality. One of the husbands stated that he saw the injury as stemming from the fact that there were "two alpha males in the relationship." The wife was the one in a position of power (defining reality) and in combination with attachment/sexual needs being neglected, the only way the injuring partner saw to assert him-

self was by violating the relationship. Given that forgiveness involves letting go of anger and the wish for revenge, which serves to re-balance the scales, it may have served the injured party to stay in a place of un-forgiveness as a way to ensure that she stayed in a position of power and claimed her revenge by having her partner suffer the burden of not being forgiven. The injured partner may benefit from bearing a grudge as there is some satisfaction at feeling in control of deciding the couple's fate (Baumeister et al., 1998; Exline & Baumeister, 2000).

The work of Vogel and Lazare (1990) suggests that the reluctance to accept the injured partner's shame has to do with the experience of having been humiliated. They suggest that a rage response is characterized by enduring and unforgiving anger that serves to protect against the destruction of the psychological self. Indeed we observed that in cases of infidelity, injured partners were less likely to forgive if the idiosyncratic meaning they attached to the EI reflected a sense of having been humiliated rather than abandoned by their partners. Our sense is that the experience of humiliation among this sub-group reflects the activation of a core, maladaptive emotion scheme organized around shame (i.e., the sense of being unworthy) that generates deeper intra-psychic disturbance than the sadness or pain that comes with feeling that one was abandoned. There is a sense that if one is rejected one might still attach again, but if one feels unworthy there is a fear of not ever feeling wanted or accepted again.

These couples involved in identity definition struggles appeared to need deeper work at stage 3 (*Accessing underlying feelings*) of the 5 stage EFT-C framework (Greenberg & Goldman, 2008) to explore and overcome the intrapsychic blocks that prevented the women from accepting their husbands' shame. It may have been the case that expressing acceptance and having empathy towards the offender was experienced as too threatening to their position of power or that a profound fear of re-injury prevented them from the possibility of taking the steps to re-establish intimate contact with the injuring partner.

In conclusion, the process of interpersonal forgiveness requires both parties to be emotionally responsive and express empathy. If the injuring partner cannot take full responsibility for the injury, he/she cannot be responsive to his/her partner's pain and will likely not move forward to expressing shame. Similarly, the injured partner must be open to accepting and thereby validating his/her partner's suffering (shame) for forgiveness to unfold. While we may have identified the "active ingredients" in interpersonal forgiveness, we wish to emphasize that these processes are embedded within a macro-process and earlier therapeutic work is needed for "scaffolding" this process of forgiveness. That is, the process of forgiveness begins with the injured partner expressing secondary anger, differentiating this into primary assertive anger and/or primary sadness, and having the injured partner tolerate these emotions in a non-defensive manner, assume responsibility for the EI, and then offer a heart-felt apology that involves an expression of shame, etc. It is equally important to note that these processes generally do not occur in one single interaction, and the injured partner's task is to be able to tolerate feeling "exposed and vulnerable" after having expressed his/her shame but not have it met with a desired response. In other words, the injuring partner must be able to tolerate the anguish that may arise as the injured

partner works on "digesting" the shame that was offered and in the process, expresses more anger and pain at having been betrayed.

Implications for Clinical Work and Relational Resiliency

Based on our research, we encourage therapists to work on facilitating interpersonal forgiveness in cases where a couple is struggling to overcome an EI (and the couple views forgiveness as relevant; if not, we advise therapists to aid the couple "let go" of the pain and hurt associated with the EI). The therapist's primary task is to facilitate the injuring partner's expression of shame in an emotionally-vivid way (rather than an intellectual one) by *reaching in and speaking the unspoken* (i.e., using empathic conjectures) until shame is alive in the room. This must be done in a non-judgmental manner to prevent shaming the injuring partner. Simultaneously, the therapist must ensure that the injured partner is able to accept this shame in a non-defensive manner, and to explore the injured partner's barriers to accepting the shame. (See Greenberg and Goldman (2008) for specific techniques used in EFT-C).

While our work has focused on helping couples overcome deep betrayals that cause serious damage to the relationship, we consider the process of forgiveness that we have outlined in this chapter to be beneficial in all intimate relationships where there is safety and mutual respect. We do not advocate for forgiveness from a moralistic standpoint. Instead, we believe that two key processes are the ability to openly discuss slights and mild, every day injuries in a non-defensive manner (by expressing underlying vulnerabilities), and the ability for both partners to assume responsibility for their actions. These couples will develop a tighter bond, a stronger sense of "we", will likely be more resilient to stress over time, and will probably forgive each other for varying degrees of EI's. This hypothesis is informed by empirical research on the positive impact of expressing vulnerability in intimate relationships (Greenberg & Johnson, 1988; McKinnon & Greenberg, 2013) and also by the notion that responsibility engenders responsiveness to the injured partner's pain (see Woldarsky Meneses & Greenberg, 2011). Moreover, the positive emotions that emerge with forgiveness nourish the relationship by acting as preventative agents ("money in the bank") to future relational tension, and are important because as Gottman and colleagues have shown (1998), it is the presence of positive emotions that enhances marital satisfaction not just the absence of negative emotions.

Future research should consider assessing the long-term impact of forgiveness, as our research conclusions are limited to a 3-month period following the end of therapy. In addition, examining how forgiveness unfolds in cases of "mild" EI's (i.e., where the integrity of the relationship is not threatened) merits attention, as it is likely these un-attended injuries that serve to establish a negative interactional cycle in couples. Lastly, as we have noted previously, future research should be conducted with couples of varying gender configurations, as all of the injured partners in the reported sample were female and all but one of the offending partners were male.

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Part IV
Looking Back, Moving Forward

Chapter 11
Resilient Couple Coping Revisited: Building Relationship Muscle

Karen Fergus and Karen Skerrett

In this volume, we have presented a collection of perspectives on couple resilience from a primarily North American perspective. Our contributors have expanded our understanding of couple resilience – both as a general phenomenon and as it manifests across varying types of stressors and life challenges. These have ranged from coping with a life threatening illness and treatment-related sexual impairment, to the constant stress of living in a heteronormative society when the couple's identity and chosen way of life are at odds with socioculturally prescribed roles and expectations. Cutting across all contributions has been a recognition of the importance of the dynamic, highly-idiosyncratic microcosm that is the "essence" of the relationship (Reid & Ahmad, 2015), the 'starter' that enables the couple to rise to each challenge as it is added to the relationship mix. This is not to suggest a glorified or idealized version of couple adaptation; to the contrary, as our contributors have emphasized, resilient reintegration, when it occurs, is a hard-won, sometimes tenuous process.

Reverberations affirming Walsh's (1996) 20-year-old assertion that resilience presents itself not *despite* hardship but *because of* it, are felt throughout this volume. Once again, however, the point is made that although adversity may be necessary

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for couple resilience, it is by no means sufficient. The couple must bring something of themselves, as a relational entity, to each challenge before them – what our collaborators and we have referred to as 'We-ness.' The process by which the couple responds to and integrates each challenge will, in turn, be defining of the relationship. According to our contributors, whether the relationship is strengthened or shattered by a stressful or traumatic experience depends on a number of key processes. In general terms, couple resilience is "the process by which partners can jointly assimilate and accommodate to fluctuating circumstances over the lifespan of their marriage in a way that maintains and enhances the integrity of their marriage" (Reid & Ahmad, 2015, p. 140). Sub-processes emerging across contributors as necessary for couple resilience include: mutual empathy, vulnerability, compassion, and respect; self-other and relationship awareness; continual consideration and prioritization of the relationship; unified meaning construction in relation to a given challenge; concerted efforts to build positivity into the relationship; a relational backdrop of safety and trust; and a storehouse of accumulated wisdom gleaned from shared life experiences. Thus the components necessary for resilient adaptation are present *long before*, as well as during and after, partners are confronted with circumstances that challenge their status quo or existence.

If positive marital adjustment grades the road to successful couple adaptation, the particular type of adversity being faced, defines the route. The adversities discussed in this volume may be broadly classified in terms of acute periods of crisis, or ongoing chronic stressors. Deep betrayals entailing a profound breach of trust, or a couple's coping with a cancer diagnosis fall within the former category, while a serodiscordant couple living under the perpetual threat of the well-partner becoming infected with HIV, reflects the latter. In other contexts, such distinctions interweave as with a gay or lesbian couple that continuously bears the weight of accumulated micro-aggressions that one day reach a crisis point when one partner is seriously injured and denied spousal health benefits; while the man afflicted with prostate cancer may be, for all intents and purposes, 'cured' by a radical prostatectomy that then severely compromises the couple's sexual intimacy for the duration of their relationship.

From an Additive to Mutual Conceptualization of Couple Coping and Resilience

Regardless of adversity type, the couple's realization of their resilience rests on the strength of the 'We' and partners' capacity for mutuality. The more fragile the 'We' is, the less resilient the couple will be. Thus although every challenge presents the couple with an opportunity to strengthen and deepen the relationship, not all couples will succeed in doing so. This emphasis extends the work of scholars who have stressed the importance of looking beyond the individualistic parameters characteristic of the early coping and adaptation literature (e.g., Lazarus & Folkman, 1984), in favor of a more 'dyadic' (Bodenmann, 2005; Gameral and Revenson, 2015; Revenson, Kayser, & Bodenmann, 2005), 'communal' (Lyons, Mickelson, Sullivan, & Coyne,

1998), 'collaborative' (Berg et al., 2008), and/or 'contextual' (Revenson, 2003) perspective. Building on this work, we wish to underscore that a couple's ability to accommodate each stressful situation is not simply the result of a summation of each partner's individual coping abilities. Such conceptualizations are based on an additive or exchange-based model of relational processes. The understanding presented here, in contrast, is rooted in the systemic notion that 1 + 1 does not equal 2, but 3 (Singer & Skerrett, 2014; Taibbi, 2009). Couples are thus advantaged by this 'third entity' that would not be available to dyads who are not as close, or who lack a history of shared, intimate relating – in other words, in dyads where the 'We' is more frail or not existent.

This fundamental assumption about where a couple's strength resides has influenced the development of assessment tools and interventions. 'We' oriented therapeutic approaches are inherently 'strengths-based' because not only do they seek to tap into each couple's unique, shared resources (e.g., communicativeness, humor, intelligence, love, loyalty), but they also recognize and respect that each couple's adaptational process will always be a distinctive expression of their unique partnership. The systemic-constructivist approach to couple therapy (SCCT; Reid & Ahmad, 2015; Reid, Dalton, Laderoute, Doell, & Nguyen, 2006) drives this point home in stressing the significance of the couple's "relational epistemology," and by treating partners like participant-observers of their relationship. As such, the couple is regarded as an integral co-investigator with the therapist in the therapeutic process. Singer and Skerrett (2014) work with the 'We' by teaching couples to develop stories that shift from a focus on what each partner needs or wants to a consciousness of the relationship. They coach couples to increasingly build stories that encompass the seven elements of we-ness: security, empathy, respect, acceptance, pleasure, humor and shared meaning and teach them to ask the fundamental question of one another-what is best for *us*? Any and all narrative and therapeutic techniques hold the health of the relationship as the ultimate objective.

Such interventions are complemented by current methods for relationship-focused assessment that have been developed with the aim of evaluating the degree to which the couple is operating with a 'We' orientation. For example, The *Marital Engagement-Type of Union Scale* (Me-to-Us) is founded upon the supposition that the strength of a couple's We may be discerned through the degree of interconnectedness of each partner's individual behavior and choices (Singer, Alea, Labunko-Messier, & Baddeley, 2015). Thus the Me-to-Us instrument assesses how this form of mutuality is occurring in a couple's day-to-day life. Similarly, Reid's and colleagues' (2006) intricate system for observationally coding the strength of the 'We' is intended to capture the extent to which each partner is accurately attuned to the other and identifies with the relationship. Also examined in this volume is how a couple's use of 'We' language and the telling of shared stories and memories may provide a barometer into the health of the relationship. In Alea and collaborators' study of relationship defining memories, the more pronounced the use of plural pronouns in couples' recounting of *negative* memories, the more likely partners were to report marital satisfaction. This led the authors to conclude that "couples in distress have lost track of a relational language" presumed to reflect a frayed sense

of togetherness or We-ness (Alea, Singer, & Labunko-Messier, 2015, p. 174). As Singer and colleagues also maintain, "a couple's attention to 'we-ness' provides a potential yardstick to assess their capacity for resilience and perseverance in the face of conflict" (Singer et al., 2015, p. 124).

Also signifying of the strength of a couple's Weness is the extent to which partners have developed a "meta-cognitive awareness" (Reid and Ahmad, 2015) within their relationship. A concept reminiscent of Gottman's (1999) "love maps," a meta-cognitive awareness entails correct knowledge of the other's feelings, thoughts, and assumptions underlying his or her actions. As Reid and Ahmad observed from their analysis of couples who underwent Systemic Constructivist Couple Therapy: "Partners that were higher in their identification with the relationship (i.e., weness) were also demonstrating a greater degree of knowing what one's partner was thinking and feeling during a discussion on a topic considered important to the couple" (p. 150), setting the couple up to be more resilient.

From 'I' to 'We' and Back Again

Despite our own and our contributors' granting We-ness primacy, it was an ironic 'discovery' for us to see just how contingent the health of the We is on the emotional maturity of the couple's respective 'I's. The importance of self-differentiation and personal individuation in the health of intimate relationships is so common an assumption in couple therapy circles so as to be a truism. Nonetheless, it came as somewhat of a surprise for us to come full circle to rediscover this to varying degrees in the array of contributions to the volume – particularly given that the concept of We-ness was suggested as an anchor point around which our authors structure their study of couple resilience and its varied demonstrations. On an individual level, the kind of characterological deficits we bring to a relationship (as well as strengths), will to a good degree demarcate the parameters of what is possible for the relationship. This point was made particularly salient in the chapter on forgiveness in Emotion Focused Therapy for couples in which healing *could only begin* with the injuring partner's humbly exposing his own profound vulnerability in an expression of deep shame (Woldarsky & Greenberg, 2015). The partner receiving this expression, in turn, had to permit her own profound hurt, anger and/or judgment to drop away, not only to be able to receive her partner's expression, but also, to empathize with it. The injured partner's ability to experience empathy and even compassion in this way toward the injuring partner – that is, to take in and experience the vulnerability in someone who has significantly harmed oneself – speaks to a high degree of emotional maturity. In Woldarsky and Greenberg's words, "Fortitude is needed to empathize with the injuring partner, to put aside one's fears of being injured again, and to have faith in the couple's ability to heal and grow instead" (p. 190).

By emotional maturity we mean individuals who, for the greater part, engage in non-manipulative, non-defensive self-expression; admit to vulnerability or self-perceived weakness; assume responsibility for one's choices and actions; whose

self esteem and self-worth are not dangerously contingent on another person's unconditional acceptance; and who are able to self-regulate painful or uncomfortable affect when feeling threatened or stretched to capacity. These personal attributes go a long way toward creating resilient partnerships. Yet we acknowledge they are in many ways representative of an 'ideal type.' In reality, such virtues are commonly expressed intermittently, and resilient relationships are also ones that are able to tolerate and accommodate human frailty while under duress.

Building Marital/Relational Muscle

Strengthening Through Stress and Repair Evidence is accumulating for the 'strong foundation' hypothesis – that resilience is not simply the end product of a couple's successfully meeting a stressful life circumstance, but also an expression of extant individual and relational strengths preceding any given stressor. Such stressors may be 'internal' to the couple as in competing values over child rearing, or 'external' to the couple as in the case of a flooded basement. Muscle physiology and more specifically *muscle-building* offers an apt metaphor for this process by which stress is necessary in order to strengthen. Indeed physiologists refer to the deliberate stressing of muscular tissue through strength or resistance training as muscle 'injury', 'trauma', and/or 'damage' (Kwon & Kravitz, 2006). Such resistance unleashes a cascade of cellular and hormonal processes that literally cause the muscle fibers to thicken and multiply. What is of note here is that muscle growth, or 'hypertrophy,' would in fact *not be possible* without such injury to the muscle fibers. It is also of note that physiological stress that *slightly exceeds* the muscle's comfortable limit is what leads to such adaptive muscle regeneration. In contrast, a muscle that is exercised within its zone of comfort helps to maintain its current level of function, while a muscle that is forced to work beyond its capacity can tear and thus be 'injured' in the commonly understood sense. Thus a muscle that strengthens in the face of resistance is like a resilient relationship, one that adaptively responds to the trauma to its living structure and grows as a consequence. Interestingly, skeletal muscle is considered to be the most adaptable tissue in the human body (Kwon & Kravitz). A relationship that falters in the face of hardship is comparable to a muscle tearing, whereas a relationship that is fortified through adversity is like a muscle that has adaptively grown with and because of it.

Likening a strong relationship to muscle regeneration also extends to Gottman's (1999) observation that the key to marital longevity is the capacity for couples to repair the relationship by repeatedly resolving or diffusing tension following conflict. More recently Gottman has promoted trust as the cornerstone of the resilient relationship (Gottman, 2011). The demonstration of trust, in turn, depends on the ability for both individuals to recognize, own, and express their vulnerability. The capacity for repair is thus severely limited without the capacity to be vulnerable to the other as it essentially denies or at least obstructs the other the opportunity to

be empathetic. It is hard to soften oneself and empathize in the face of a defensive blockade be it frigid or incendiary. Thus if one or both parties cannot admit to their vulnerability, it may get acted out in ways that are not constructive to the relationship, and the potential for intimate interaction is short-circuited. When one partner shares vulnerability, in contrast, and the other is able to receive and appropriately respond to that vulnerability, it builds trust in the capacity of the relationship to be resilient and adaptive. It sends the message to both parties that this relationship can tolerate my vulnerabilities, that it 'has muscle,' which in turn builds trust in the relationship's ability to be there for oneself.

Reparation and trust go hand in hand as partners come to learn with time that the relationship will endure despite daily upheavals, stubborn disagreements, or periods of extreme relational distress or crisis. In this sense the relationship itself becomes a safety net into which partners may stumble and fall, or sometimes crash, yet from which partners can rebound, dust themselves off, and carry forward. Woldarsky and Greenberg (2015) make a similar point in relation to everyday "slights." When partners respond to such minor injuries non-defensively, by sharing vulnerability and taking responsibility where warranted, the relational bond strengthens. Thus they suggest that the capacity to admit to and forgive *minor* injuries on a day-to-day basis may better equip couples to deal with more significant breaches or transgressions, if these are to occur, later on.

Atkinson's (2013, 2015) emphasis on mindfulness practice as a vehicle for increased relationship fulfillment fits well with the idea that a relationship may be strengthened through training just as a muscle can be. In his review, he provides growing evidence for how mindfulness meditation not only benefits a range of conditions (e.g., depression, post-traumatic stress disorder, elevated blood-pressure) but it also enhances our interactions with others by improving one's ability to regulate strong affect, be more attentive and empathetic, and be flexibly responsive rather than reactive (Atkinson, 2015). As he states, "Thus mindfulness meditation may increase resilience via two avenues – one direct (through strengthening resilience-related brain areas) and the other indirect (through enhancing the quality of relationships)" (Atkinson, 2015, p. 111). Therefore, regular mindfulness practice is one means to achieving *relationship fitness*. The more fit respective partners are in a mindful sense, the more able they are to mutually self-regulate (Atkinson, 2005; Cozolino, 2006; Fishbane, 2013) and achieve the COAL (curious, open, accepting, loving) state (Siegel, 2006) on a more frequent and consistent basis. This form of relationship fitness is likely, in turn, to strengthen the couple's capacity to respond in a mutually supportive, adaptive way during stressful situations. Effectively, couples that pursue mindfulness training are exercising their brains today for better adaptation tomorrow.

Relationship fitness depends on both strength *and* flexibility. A muscle that is too tight or rigid and lacking in flexibility is more susceptible to injury. The concepts of elasticity and plasticity are relevant here and, when applied to resilience processes, parallel Lepore and Revenson's (2006) "recovery" and "reconfiguration" resilience types respectively. Elasticity involves a return to the original state and level of functionality. In the case of couple adaptation, partners who have 'recovered' in this

sense have been through a stressful experience but are able to "pick up where we left off" and reclaim their prior state of normalcy. Plasticity, in contrast, entails a form of remodeling, a 'going beyond' and staying there. Thus rather than returning to the original state, a new state is reached and accommodated. It could be argued that resilient reintegration (Richardson, 2002), by definition, is a process of reconfiguration, and therefore a plastic one. Some stressors are of such a magnitude or quality that successful adaptation necessitates reconfiguration or couple plasticity. Where couples get caught is in striving for, or wishing for, elasticity when it is plasticity that is available to them.

Beck and Robinson (2015; Beck, Robinson, & Carlson, 2013) propose a form of couple plasticity in their PRISM model (Physical Pleasure – Relational Intimacy Model of Sexual Motivation) where resilient couple sexuality begins with acceptance. For couples coping with erectile dysfunction, for example, for each time they are unsuccessful in having penetrative sex, the couple takes one step more towards a cumulative experience failure. Couples typically become frustrated if they are not able to recapture their previous sexual relationship, and many stop being intimate altogether. What is required instead, according to the model, is acceptance of the current situation followed by flexibility and a willingness to explore forms of sexual expression that deviate from the couple's existing sexual norms and script. The PRISM model frames couple sexuality as relational and dynamic with intersecting motivations of intimacy and physical pleasure. In situating themselves along these dimensional coordinates, partners become more aware of what is driving the sexual act for each individual. By stepping back to examine broader goals in relation to sex, couples are in a better position to envision alternative avenues to achieving these goals. In Beck and Robinson's words, "When a person is able to set aside the frustration and the resentment, and instead accept the situation as it is, then one gains the intellectual and emotional resources needed to consider solutions and alternative ways of maintaining the sexual relationship" (2015, p. 72).

Thus, couple resilience depends on the ability for partners to demonstrate flexibility not only behaviorally, but also *conceptually* which might require revisiting and questioning long-held beliefs, values, attitudes, and patterns of thought. For couples in non-normative relationships such as LGBT couples, societal introjects are experienced as an imposition from the very start. "The process of de-centering heteronormativity, and developing supportive communities, has given lesbian and gay couples the ability to re-vision their relationships, and create unique family forms. The nature of same-sex coupling allows for greater diversity in how families are organized around gender, and influences greater flexibility in all areas of life from household chores to sexual intimacy" (Lev-Star, 2015, p. 57). Thus, more differentiated and original definitions of how partners can be and experience, for example, intimacy, sexuality, wealth, excitement, fun, parenting, play, healthy living, 'quality time,' and a sense of 'family' and community – set the stage for relational plasticity. Acceptance of *what is* followed by flexible adaptation permits a "bouncing forward" (Walsh, 2003) into something new, rather than an elastic return to what was and is no longer. When achieved, this developmental feat, in turn, leads to a stronger, richer, and more variegated We.

Ongoing Nurturance and Recommitting to the Relationship The structural integrity of the 'We' depends not only on the continuous process of stress and repair, but also on the ongoing nurturance and prioritization of the relationship by each partner. While the former constitutes life vicissitudes that are beyond the couple's control and often, preference, the latter is, fortunately, a matter of choice. As any serious athlete or dancer will attest, muscles must be attended to, stretched and massaged; otherwise they will stiffen, lose their elasticity, and become more prone to injury on the day of the big event. Our contributors similarly hold the view that relationships need to be attended to and nurtured in order to be flexible and resilient when confronted with challenging life situations. More specifically, resilient couples continuously engage in a recommitment to, and reprioritization of, their We – that shared entity that is greater than either individual alone (Singer & Skerrett, 2014; Skerrett, 2015).

A We-orientation is a mindset that each partner brings to the relationship where each is prepared to make a gesture, time and again, toward the 'We' – toward that which resides within and between them. Once again, this attitude requires a bending of the frame through which we have historically viewed intimate relationships from a monocular view comprised of two 'I's in cybernetic interaction, to a binocular lens that is broad and inclusive enough to encompass the greater 'We' gestalt. When there are competing motivations and desires in the relationship and one partner chooses to bend so as to accommodate the other, the binocular view considers this a *gesture* toward the greater We of the couple, rather than the *sacrifice* seen through a monocular lens that one person is making – sometimes begrudgingly, sometimes lovingly – for the other. Each such *gesture* is a small but significant act of recommitment to the relationship and invariably benefits the giver as well as the receiver because the good feeling it provokes replenishes the well from which both partners drink.

Future Directions

The work of the contributors to this volume have simultaneously extended the thinking on couple resilience and pointed the way toward all the work yet to be done. Given our complex definition that includes both process and outcome (and related dynamic interplay), we have many points of entry to research couple resilience. Firm believers in the complementarity of many research paradigms, we suggest three organizing principles with which to think about and approach the work ahead. These principles are promixal/distal contributions, differential impacts, and contextual and cultural moderators. In light of the systemic, dynamic lens that we apply, it is important for scholarly work to identify the perspective utilized and/or emphasized in any particular body of work.

The bulk of existing research has focused on the examination of the ways couples both navigate their path to the resources they need to cope with a challenge, and the various ways they interact with the resources to meaningfully adapt.

Little work has tackled the before and after question: What did individual and relationship functioning look like prior to the adverse event(s)? In order to effectively address our belief that 'we' functioning confers numerous advantages, we have to design the kind of rigorous controlled studies that will allow us to assess the relative contributions of gender, personality style, environmental resources, relational dynamics and determine how they impact 'we' coping. Specifically, what kinds of responses to adversity are associated with couples scoring at various points along the continuum of we-ness (We to Us scale) from low to high? Do higher scores predict greater mutuality, marital satisfaction or other indicators of marital quality? Can couples with low we-ness profiles be assisted to build a stronger we, and how does their coping compare to that of the couples who come to a challenge with a more viable or vigorous we? Since evidence suggests that female partner experience of a relationship has greater impact on particular dimensions of marital quality such as health and mutuality (Alea et al., 2015; Singer et al., 2015), how does that apply to we-coping or play out in same gender relationships? This leads us to a consideration of our first principle-that of multiple contribution.

Proximal/Distal Contributors It is important for future research to acknowledge that there are many proximal as well as distal processes that can and do lead to very different but effective expressions of relational resilience. Examples of proximal contributors might be the health status of the partners or the number of stressors impacting partners, the educational experience and language facility. Distal contributors would include each partner's family of origin templates for dealing with challenges, the mediating impacts of prior success in dealing with adversity, or cultural or gendered norms and expectations. Research should clarify the kinds of contributors impacting resilience, their relative importance and when possible, the interaction between them. It would also be valuable to know more about past coping successes and particularly the ways in which we might leverage them to help partners better deal with the challenge at hand. Has the 'we' shown up in other adversities/challenges? Specifically how?

Differential Impact As this volume has repeatedly emphasized, not only do challenges impact individuals in multiple and complex ways but they impact couples likewise. It would be valuable to develop profiles of we-coping across couples; what couple types confer greater or lesser relational resilience? How do these profiles further distinguish themselves at various points in the lifecycle of the relationship?

Prospective, longitudinal designs and daily experiential sampling are excellent means to elucidate the dyadic mechanisms through which relationship and other factors mutually influence one another. Incorporating modern technology, such as video and smartphones would assist us to look at interactions in more detail. Smaller level studies (e.g., in depth qualitative, single or replicated case designs) would also allow us to work with a smaller number of couples in more detailed ways. Since the bulk of current research only provides a moment-in-time assessment of relationship functioning and a person's sense of we-ness, experimental manipulation studies would allow us to make more causal statements about the differential impact of we-ness mechanisms. For example, do couples scoring high in empathy also initiate

more care-taking actions than couples low in empathy? As several of our contributors suggest, perhaps there is an inverted U curve for we-ness such that more may not be better (Alea et al., 2015).

Studies such as these would contribute to our ability to make distinctions between resilience as recovery (from adversity) and resilience as the maintenance of relationship quality and development in the face of cumulative risks. These distinctions would underscore the 'both/and' nature of resilience; resilience isn't simply recovery from adversity but also an expression of pre-existing strengths. Highlighting the differential impact of challenges on couple life will also help us to identify the various forms that couple resilience can take. For example, what are the continuities and discontinuities among couples coping with the birth of a child, the illness of a child, couple coping with a chronic or degenerative illness, couples in which one or both partners has a serious mental illness. Given the fact that the challenge of overcoming substance dependence and addiction is characteristically framed as an 'individual' problem, researchers would do well to apply the lens of we-coping to future work with this difficult issue. What are the particular coping or adaptational tasks and/or milestones involved in a 'we' oriented response to such adversities?

Contextual and Cultural Moderators Research with couples has long been criticized for its' focus on white, heterosexual, middle-class subjects – the 'University-setting' bias. To increase representativeness and generalizability of findings, future work must strive to incorporate diverse populations. In particular, work on couple resilience needs an expanded focus on the underserved – those with the least access to resources known to boost resilience. Minorities and the poor are often those living with the greatest stress, risk and vulnerability to chronic adversity. Studies should attend to the generalizability of findings across potential moderators such as age, gender, family life cycle, culture and ethnicity (interethnic couples), family structure (composition of extended and stepfamily systems), and co-habitating and same gender couples. Cross-cultural comparisons remain rare despite documented differences in how couples of diverse cultural backgrounds contend with mental and physical stressors.

Finally, we encourage researchers to incorporate the examination of the role of the larger community in supporting couple and family resilience. Models that represent a broad couple ecology that includes both micro and macro systemic supports would help us identify the factors that interrupt the experience of daily stress and avert delays in adaptation to subsequent stressors.

Conclusion

This chapter presented a synthesis of ideas across contributors to the book, *Couple Resilience*, *Emerging Perspectives*. Certain themes emerged as necessary for optimal couple coping and adaptation – some of which affirmed our original thinking about couple resilience and some of which expanded it. Among these insights were: (1) couple resilience is not merely an outcome following adversity, but an

expression of an ongoing, resilient process that is dynamic and specific to each couple; (2) consistent with thinking about resiliency in general, couple resilience occurs not *in spite of* hardship but *because of* it; (3) adversity, although necessary for couple resilience, is by no means sufficient; the degree of resilience rests on the strength of the couple's shared identity or 'We-ness'; (4) successful couple coping is a byproduct of the 'We' (i.e., $1+1=3$) rather than simply a summation of individual partner strengths or coping abilities (i.e., $1+1=2$); (5) the parameters of the 'We' are demarcated by the characterological strengths and deficits of respective partners. Processes important for couple resilience and the cultivation of strong relationships may be likened to muscle building, an analogy that we have found to be useful in clarifying how relationships may be strengthened by adversity. The co-occurrence between overall couple distress and specific relationship problems as well as individual emotional or behavioral disorders has been well established in the research literature. It is our hope that this volume generates enthusiasm to build a literature devoted to understanding the factors that support couple strengths, couple flourishing and the elements that build and nurture relational quality.

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